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FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

13293
13276
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>Hillcrest Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Magdaline Atkinson</u>				4. DATE OF DEATH <u>Dec. 31, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1909</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN Witt</u>				14. MOTHER'S MAIDEN NAME <u>Julia Davidson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John J. Atkinson</u> Address <u>Cumberland Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACRANIAL HEMORRHAGE</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SKULL FRACTURE</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u> <u>"</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL DOWN STEPS</u>					
20c. TIME OF INJURY Month, Day, Year <u>10:00 p.m. DEC. 22 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>R.D. Cumberland, Alleg. Md.</u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>		EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>December 31, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 3, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or country) <u>Cumberland Md.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR <u>Byron Knight</u>		ADDRESS <u>Cumberland Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 8 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO THE
HONORABLE
COMMISSIONER
OF THE
LAND OFFICE
WASHINGTON, D.C.

FROM
J. H. HARRIS
SPECIAL AGENT IN CHARGE
OF THE
FOREST SERVICE
WASHINGTON, D.C.

SUBJECT
RECEIVED
JAN 1 1901
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

RECEIVED
JAN 1 1901
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

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TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13294
13277

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b 5 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MIDLAND, d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First Middle Last BAMPTON		4. DATE OF DEATH Month Day Year DECEMBER 19TH, 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 16TH, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOUSEWORK	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY McKEE		14. MOTHER'S MAIDEN NAME CHARLOTTE McKENZIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. MISS ELLEN BAMPTON, MIDLAND, MD.	
17. INFORMANT NONE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) NONE		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 20 yrs?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/13 , 19 61 to 12/19 , 19 61 , that (I) (we) saw the deceased alive on 12/19 , 19 61 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein M.D.		22b. DATE SIGNED 12/20/61	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN,		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-22-61	
23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Thurst		25a. REC'D BY REGISTRAR DEC 26 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13295

CERTIFICATE OF DEATH

13278

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE			
c. LENGTH OF STAY IN 1b 40 YRS.				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)							
3. NAME OF DECEASED (Type or print) First LOUISE Middle B. Last BARNCORD				4. DATE OF DEATH Month DEC. Day 11 , Year 19 61			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 4, 1888	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73 Days 73	IF UNDER 24 HRS. Hours 73 Min. 73	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WM. G. STEWART			
14. MOTHER'S MAIDEN NAME ALMEDIA WILLIAMS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NONE			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Address MRS. RAYMOND HIMMELWRIGHT, MT. SAVAGE,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Arteriosclerosis (a), stating the underlying cause last. (c) Generalized Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7.31.1961 to 12-11-1961 , that (I) was last saw the deceased alive on 12-6-61 , and that death occurred 11:00 from the causes and on the date stated above.							
22a. SIGNATURE W. F. Williams M.D.				22b. DATE SIGNED 12/12/61			
22c. PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M. D.				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-14-61		23c. NAME OF CEMETERY OR CREMATORIUM ST. GEORGE EPISCOPAL		23d. LOCATION (City, town or county) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE L. P. Burt				25a. REC'D BY REGISTRAR DEC 18 '61			
25b. REGISTRAR'S SIGNATURE C. S. Kline							

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VR A15 (4)
15M 9/60

13322



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13296
13279
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		4. DATE OF DEATH Month Dec. Day 14 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 9, 1878
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Wife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Somerfield		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Jacob Bishop-R.D. 1-Westernport, Md.	
17. INFORMANT Jacob Bishop-R.D. 1-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Cardiovascular failure DUE TO arteriosclerosis (b) arthritis DUE TO arthritis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 Days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10 PM , 19 61 , to 12/14 , 19 61 , that (I) (we) last saw the deceased alive on 12/14 , 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE J B Davis		22b. DATE SIGNED 12/14/61	
22c. PHYSICIAN'S NAME (Type) John B. Davis, MD		22d. ADDRESS 2 B. ROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/61	
23c. NAME OF CEMETERY OR CREMATORY Bloomington		23d. LOCATION (City, town, or county) (State) Bloomington, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Boal's Fun. Service		25a. REC'D BY REGISTRAR DEC 18 '61	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

CERTIFICATE OF MARRIAGE

1933

State of New York

County of

City of

On this day of

1933

I, the undersigned

Minister of the Gospel

do hereby certify

that the within and foregoing

is a true and correct copy of the original

record

Witness my hand and seal

Minister of the Gospel

Signature

Recorded

Index

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 60 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13297
CERTIFICATE OF DEATH

13280

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN TB 37 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 122 COLUMBIA ST., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last MARY E BLAKE			4. DATE OF DEATH Month Day Year DECEMBER 5 19 61		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1915	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME J. CARL CESSNA			14. MOTHER'S MAIDEN NAME ELLEN MILLER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma Cervix (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1960	
20f. (City or town) Dec 5		20g. (County) 1961		20h. (State) 1961	
21. I certify that (I) (this hospital) attended the deceased from 1960 to Dec 5 , that (I) (we) last saw the deceased alive on Dec 4 19 61 , and that death occurred at 7:00 AM from the causes and on the date stated above.					
22a. SIGNATURE William P. James		22b. DATE SIGNED 12-5-61		22c. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES	
22d. ADDRESS 441 N. CENTER ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.	
23d. LOCATION (City, town or county) Cumberland, Md.		23e. REC'D BY REGISTRAR DEC 8 61			
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		24b. ADDRESS Cumberland, Md.		25a. REGISTRAR'S SIGNATURE William P. James	



ALLEGANY

CLEVELAND

CHORALHOSPITAL

WAWY

K

WHITE

JOHN CARL CROSBY

WARTLAND

CLEVELAND

ST. BAYS

122 COLUMBIA ST.

BLAKE

DECEMBER 3

JUNE 1, 1915

MT. SAVAGE, MD.

ELEANOR MILLER

HOSPITAL HOSPITAL

Handwritten notes:
L. J. ...
L. J. ...

1:00 AM

ONE

Handwritten: L. J. ...

WILLIAM P. THOMAS

141 W. CENTER ST., CLEVELAND, OH.

Handwritten: ...

Handwritten: ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For a burial, cremation, or removal, file pages 1 and 2 with the registrar for a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

After receiving telephone advice from State Dept. of Vital Statistics, Dr. M. Skitarelic, Allegany Co. Deputy Medical Examiner, was asked to investigate and sign this certificate.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 514648

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Paw Paw, West Virginia				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. #1, Paw Paw, W. Va.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Paw Paw, West Virginia		f. STREET ADDRESS R.F.D. #1, Paw Paw, W. Va.	
3. NAME OF DECEASED (Type or print) First FLOYD Middle HARRISON Last BOYER				4. DATE OF DEATH Month December Day 8 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1889	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Petersburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-26-1690		17. INFORMANT Mrs. Emiline Boyer, Rt. #1, Paw Paw, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio vascular heart disease DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER XXXXXX		DATE SIGNED 1-7-62	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1961		22c. NAME OF CEMETERY OR CREMATORY Green Ridge Cemetery		22d. LOCATION (City, town, or county) (State) near Oldtown, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Parks-Johnson Funeral Home, Berkeley Spring, W. Va.				ADDRESS Green Ridge Cemetery		24a. REC'D BY REGISTRAR JAN 9 '62	
						24b. REGISTRAR'S SIGNATURE Charles L. Thomas	

STATE DEPARTMENT OF HEALTH—BALTIMORE, MD. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13281

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.D. # 1 HYNDMAN	
c. LENGTH OF STAY IN 1b 23 Hrs.		d. STREET ADDRESS 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital-Cumberland, Md.			
3. NAME OF DECEASED (Type or print) FRANK		4. DATE OF DEATH Dec. 7 1961	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> BRADY		8. DATE OF BIRTH May 14, 1880	
9. AGE (in years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Owen Brady		14. MOTHER'S MAIDEN NAME Malinda Burkett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 176-7A	
17. INFORMANT Memorial Hospital -Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Sclerosis (c) DUE TO cause listed. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal Pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . * Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10, 1961	
22c. NAME OF CEMETERY OR CREMATORY Comps Cemetery		22d. LOCATION (City, town, or country) (State) Hyndman, Pa. RD#1	
23. FUNERAL DIRECTOR Harvey A. Teigler		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR DEC 13 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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TO HOSPITAL
death certificate page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13300

13282

1. PLACE OF DEATH e. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 540 Rose Hill Ave.,		d. STREET ADDRESS 540 Rose Hill Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE GUY BRENGLE		4. DATE OF DEATH Month Day Year Dec. 19, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1877
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Postal Employee U. S. Gov't		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence T. Brengle		14. MOTHER'S MAIDEN NAME Clara Fechtig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. Mrs. R. Finley Thompson 540 Rose Hill Ave	
17. INFORMANT Cumb. Md.		Address Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO Hypertensive Chronic vascular dis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 9 Hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-11-61 to 12-19-61 , that (I) (was) last saw the deceased alive on 12-19-61 , and that death occurred 9:20AM from the causes and on the date stated above.			
22a. SIGNATURE W. F. Williams M.D.		22b. DATE SIGNED 12/20/61	
22c. PHYSICIAN'S NAME (Type) W. F. Williams M.D.		22d. ADDRESS 122 So. Centre St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR DEC 26 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

1388

1388



Handwritten signature or name, possibly "Charles C. ..."

Handwritten date: 12-11-14

Handwritten signature or name, possibly "Charles C. ..."

Charles C. ...

Page 4
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13301

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13283

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/4/1960	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Archibald Middle Broadwater Last Broadwater		4. DATE OF DEATH Month December Day 1 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ***		14. MOTHER'S MAIDEN NAME Elizabeth Broadwater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. P.O.Box 599, Cumberland, Md.	
17. INFORMANT Allegany County Infirmary records.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, degenerative, senile DUE TO 610X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis of cerebral arteries DUE TO Hypertrophic prostatic (c) Hypertrophic prostatic	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/4/60 19 to 12/1/61 19, that (I) (we) lost saw the deceased alive on 12/1/61 19 @ 11:30 P.M. and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 12/2/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/61	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City, town, or county) (State) Moscow Mills Md.	
24. FUNERAL DIRECTOR'S SIGNATURE St. Boal ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DEC 5 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

13301

CERTIFICATE OF DEATH

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Allyson County Jail

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Allyson County Jail

Allyson County Jail

Allyson County Jail

12/1/81

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12/1/81

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13302

CERTIFICATE OF DEATH

13284

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE 1, FROSTBURG			
c. LENGTH OF STAY IN 1b 18 DAYS				d. STREET ADDRESS ROUTE 1, FROSTBURG			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE WILLIAM BRODE				4. DATE OF DEATH Month DECEMBER Day 3RD , 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 11TH, 1887	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. CUSTODIAN				10b. KIND OF BUSINESS OR INDUSTRY ELKS LODGE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME DANIEL C. BRODE				14. MOTHER'S MAIDEN NAME ROSENA LEMMERT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.1				16. SOCIAL SECURITY NO. 218-03-6922			
17. INFORMANT WM. BRODE, 6 STANDISH ST., FROSTBURG, MD.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 3 1961 to Dec 3 1961 , that (I) (we) last saw the deceased alive on Dec 3 1961 , and that death occurred 12:53 PM from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane M.D.				22b. DATE SIGNED 12-4-61			
22c. PHYSICIAN'S NAME (Type) W. O. MCLANE				22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-6-61		23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Dussel				25a. REC'D BY REGISTRAR DEC 7 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kinnard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



Wm Lloyd Garrison

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

13303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13285

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg (Rt. #3 Eckhart)		d. STREET ADDRESS Box 25	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERNARD Middle DESALES Last BYRNES		4. DATE OF DEATH Month 12 Day 11 Year 19 61	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/22
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 3 Days 11	IF UNDER 24 HRS. Hours 19 Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Mail Dept.		10b. KIND OF BUSINESS OR INDUSTRY Times-News	
11. BIRTHPLACE (State or foreign country) Eckhart, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard J. Byrnes		14. MOTHER'S MAIDEN NAME Loretta Maher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-18-1012	
17. INFORMANT Bernard J. Byrnes, Rt. #3, Box 25,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THORACIC HEMORRHAGE; RUPTURED LIVER; 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CRUSHED CHEST DUE TO (c)		INTERVAL BETWEEN ONSET OF DEATH 16 hrs 16 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injured in automobile accident	
20c. TIME OF INJURY Month, Day, Year Hour 9:00 a. m. Dec 10 19 61 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Newberry Garrett Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE WOMc Lane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WOMcLANE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/61	
22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bertha H. Winters		24a. REC'D BY REGISTRAR DEC 18 '61	
ADDRESS 23 E. Main Street, Frostburg		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF MEDICAL EXAMINER		12. SIGNATURE OF WITNESS		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF DEPUTY SHERIFF		19. SIGNATURE OF CONSTABLE		20. SIGNATURE OF JURY	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF CONSTABLE	
26. SIGNATURE OF JURY		27. SIGNATURE OF JUDGE		28. SIGNATURE OF CLERK		29. SIGNATURE OF SHERIFF		30. SIGNATURE OF DEPUTY SHERIFF	
31. SIGNATURE OF CONSTABLE		32. SIGNATURE OF JURY		33. SIGNATURE OF JUDGE		34. SIGNATURE OF CLERK		35. SIGNATURE OF SHERIFF	
36. SIGNATURE OF DEPUTY SHERIFF		37. SIGNATURE OF CONSTABLE		38. SIGNATURE OF JURY		39. SIGNATURE OF JUDGE		40. SIGNATURE OF CLERK	
41. SIGNATURE OF SHERIFF		42. SIGNATURE OF DEPUTY SHERIFF		43. SIGNATURE OF CONSTABLE		44. SIGNATURE OF JURY		45. SIGNATURE OF JUDGE	
46. SIGNATURE OF CLERK		47. SIGNATURE OF SHERIFF		48. SIGNATURE OF DEPUTY SHERIFF		49. SIGNATURE OF CONSTABLE		50. SIGNATURE OF JURY	
51. SIGNATURE OF JUDGE		52. SIGNATURE OF CLERK		53. SIGNATURE OF SHERIFF		54. SIGNATURE OF DEPUTY SHERIFF		55. SIGNATURE OF CONSTABLE	
56. SIGNATURE OF JURY		57. SIGNATURE OF JUDGE		58. SIGNATURE OF CLERK		59. SIGNATURE OF SHERIFF		60. SIGNATURE OF DEPUTY SHERIFF	
61. SIGNATURE OF CONSTABLE		62. SIGNATURE OF JURY		63. SIGNATURE OF JUDGE		64. SIGNATURE OF CLERK		65. SIGNATURE OF SHERIFF	
66. SIGNATURE OF DEPUTY SHERIFF		67. SIGNATURE OF CONSTABLE		68. SIGNATURE OF JURY		69. SIGNATURE OF JUDGE		70. SIGNATURE OF CLERK	
71. SIGNATURE OF SHERIFF		72. SIGNATURE OF DEPUTY SHERIFF		73. SIGNATURE OF CONSTABLE		74. SIGNATURE OF JURY		75. SIGNATURE OF JUDGE	
76. SIGNATURE OF CLERK		77. SIGNATURE OF SHERIFF		78. SIGNATURE OF DEPUTY SHERIFF		79. SIGNATURE OF CONSTABLE		80. SIGNATURE OF JURY	
81. SIGNATURE OF JUDGE		82. SIGNATURE OF CLERK		83. SIGNATURE OF SHERIFF		84. SIGNATURE OF DEPUTY SHERIFF		85. SIGNATURE OF CONSTABLE	
86. SIGNATURE OF JURY		87. SIGNATURE OF JUDGE		88. SIGNATURE OF CLERK		89. SIGNATURE OF SHERIFF		90. SIGNATURE OF DEPUTY SHERIFF	
91. SIGNATURE OF CONSTABLE		92. SIGNATURE OF JURY		93. SIGNATURE OF JUDGE		94. SIGNATURE OF CLERK		95. SIGNATURE OF SHERIFF	
96. SIGNATURE OF DEPUTY SHERIFF		97. SIGNATURE OF CONSTABLE		98. SIGNATURE OF JURY		99. SIGNATURE OF JUDGE		100. SIGNATURE OF CLERK	

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

13304 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13286

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW YORK b. COUNTY MADISON	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GEORGETOWN	
c. LENGTH OF STAY IN 1b 9 MONTHS		d. STREET ADDRESS 69 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last CARR		4. DATE OF DEATH Month DEC. Day 23 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 6 Days 9 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB MULLENAX		14. MOTHER'S MAIDEN NAME REBECCA SIMMONS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HETTY REEL		Address CABINS, W. VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBELLAR NECROSIS WITH HEMORRHAGE DUE TO (b) ARTERIAL SCLEROSIS WITH THROMBOSIS DUE TO (c) MYOCARDIAL INFARCTION, OLD.			INTERVAL BETWEEN ONSET AND DEATH 36 Hrs. RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION, OLD.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DATE SIGNED DECEMBER 23, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 27, 1961	
22c. NAME OF CEMETERY OR CREMATORY GEORGETOWN CEMETERY		22d. LOCATION (City, town, or country) (State) GEORGETOWN, N. Y.	
23. FUNERAL DIRECTOR BYRON KIGHT		24a. REC'D BY REGISTRAR DEC 27 '61	
ADDRESS CUMBERLAND, MD.		24b. REGISTRAR'S SIGNATURE <i>C. S. Kight</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13305

CERTIFICATE OF DEATH

13287

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 820 NORTH MECHANIC ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAUL Middle O Last CARTER		4. DATE OF DEATH Month DECEMBER Day 19 Year 1961					
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5, 1925	9. AGE (In years last birthday) 36 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver Chaney Transfer Co.	11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HARRY CARTER			14. MOTHER'S MAIDEN NAME MARY L. THOMAS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) W.W. #2		16. SOCIAL SECURITY NO. 219-14-6809	17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte imbalance + uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerulonephritis DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 6 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Dec 12 1961 to Dec 19 1961 , that (I) (we) last saw the deceased alive on Dec 19 1961 , and that death occurred 11:05 AM , from the causes and on the date stated above.							
22a. SIGNATURE Walter N. Himmler WALTER N. HIMMLER		22b. DATE DEC 27 '61	22c. PHYSICIAN'S NAME (Type) WALTER N. HIMMLER 22d. ADDRESS 412 N. MECHANIC ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/61	23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montan		25a. REC'D BY REGISTRAR DEC 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13303

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CUMBERLAND

7 DAYS

CUMBERLAND

850 NORTH MECHANIC ST

MEMORIAL HOSPITAL

DECEMBER 19

EASTER

PAUL

38

APRIL 5, 1952

COLORED

WIFE

HARRY L. THOMAS

HARRY CARTER

MEMORIAL HOSPITAL CUMBERLAND, MD.

219-11-5509

...

Chronic glomerulonephritis
Charlottesville, Virginia

Dec 13 11:05 AM

Walter N. ...

412 N. MECHANIC ST., CUMBERLAND, MD.

WALTER N. ...

12/13/51
Walter N. ...
412 N. Mechanic St., Cumberland, Md.

13306

MEDICAL CERTIFICATION

VR A15 (4)
15M 7/61

1308

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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13307
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13289
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport Luke		c. LENGTH OF STAY IN 1b 34 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pratt St. Ext.		d. STREET ADDRESS Pratt St. Ext.	
3. NAME OF DECEASED (Type or print) Victoria Colia		4. DATE OF DEATH Month Dec. Day 8 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1882
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholia Serpone		14. MOTHER'S MAIDEN NAME Lucia Tromba	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Sam Colia	
17. INFORMANT Sam Colia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 331 X DUE TO HemiPlegia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis. (c) 4yrs.		INTERVAL BETWEEN ONSET AND DEATH 12dys	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 25 to Dec 8 , that (I) (we) last saw the deceased alive on Dec 7th 19 61 and that death occurred at 2.55 from the causes and on the date stated above.		22a. SIGNATURE James H. Wolverton	
22b. SIGNATURE James H. Wolverton		22c. PHYSICIAN'S NAME (Type) James H. Wolverton	
22d. ADDRESS Piedmont, W. Va.		22e. DATE SIGNED 12/8/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/61	
23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal		25a. REC'D BY REGISTRAR DEC 12 '61	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE James H. Wolverton	

STATE OF TEXAS
COUNTY OF DALLAS

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13308

CERTIFICATE OF DEATH

13290

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 9 HRS. 50 MIN. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1 10 DECATUR STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) HOWARD E. COOPER		4. DATE OF DEATH Month DECEMBER Day 10 Year 19 61		5. SEX MALE 6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 9-8-1918		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST		10b. KIND OF BUSINESS OR INDUSTRY FORD'S DRUG STORE		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA (Shinston)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HOY COOPER		14. MOTHER'S MAIDEN NAME LULA WITHERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 233-16-9686		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Generalized Arteriosclerosis DUE TO Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 11 hr												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Dec 12/1961 to 12/10/1961 that (I) (we) last saw the deceased alive on 12/10/1961 and that death occurred at 4:50 A.M. from the causes and on the date stated above.											
22a. SIGNATURE DR. GEORGE M. SIMONS				22b. DATE SIGNED 12/12/61		22c. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS		22d. ADDRESS ALGOQUIN HOTEL - CUMBERLAND, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/13/61		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, 230 Baltimore Ave. Cumberland, Md.				25a. REC'D BY REGISTRAR DEC 15 61		25b. REGISTRAR'S SIGNATURE Arthur S. ...													

33303



ALLEGANY

CHICKLAND

MEMORIAL HOSPITAL

HOMER

XX

WHITE

MALE

PHARMACIST

JOY COOPER

FORT'S DRUG STORE

COLA WITERS

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

[Handwritten signature and notes, mostly illegible]

DR. ORVILLE STONE

ALLEGANY HOSPITAL - CUMBERLAND, MARYLAND

ALLEGANY

MARYLAND

CUMBERLAND

DR. STONE

TO OLD TOWN STREET

COOPER

DECEMBER 10

1913

WEST VIRGINIA HOSPITAL

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. DURRETT									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13309 CERTIFICATE OF DEATH 13291									
1. PLACE OF DEATH a. COUNTY ALLEGANY CO. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MEMORIAL HOSPITAL CUMBERLAND, MD. c. LENGTH OF STAY IN 1b 38 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL CUMBERLAND, MD.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 715 MARYLAND AVE. d. STREET ADDRESS 1 CUMBERLAND, MARYLAND e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ABBIE G. COPELAND					4. DATE OF DEATH 12-23 19 61				
5. SEX FEMALE					6. COLOR OR RACE WHITE				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 1-21-1875				
9. AGE (In years, last birthday) 86 yrs.					IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK					10b. KIND OF BUSINESS OR INDUSTRY AT HOME				
11. BIRTHPLACE (County & State, or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME COPELAND, JAMES W.					14. MOTHER'S MAIDEN NAME MEYERS, REBECCA E.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. NONE				
17. INFORMANT Miss Ada B. Thomas					Address 503 Maryland Avenue, Cumberland, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X DUE TO massive cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from June 19 59 to Dec 23 1961 , that (I) (we) last saw the deceased alive on Dec 23 1961 , and that death occurred at 8:00 P.M. the causes and on the date stated above.									
22a. SIGNATURE Clay Durrett					22b. DATE SIGNED 12/24/61				
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT					22d. ADDRESS 186 VIRGINIA AVE., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 12/26/61				
23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery					23d. LOCATION (City, town or county) (State) Cumberland Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox					25a. REC'D BY REGISTRAR DEC 27 '61				
ADDRESS Cumberland Maryland					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

DR. CLAY DURRETT

1930



ALLIANCE CO.

38 DAYS

MEMORIAL HOSPITAL CUMBERLAND, MD.

CUMBERLAND, MARYLAND

WHITE

CUMBERLAND

12-25

FEMALE WHITE

1-21-1875

MARYLAND

U.S.

CUMBERLAND, MARYLAND

KEYERS, 12 BECCA II.



[Faint, illegible handwritten text, possibly a signature or notes.]

DR. CLAY DURRETT

100 VIRGINIA AVE., CUMBERLAND, MD.

WASH. B. STICK, CUMBERLAND, MARYLAND

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET ANN CROMWELL		4. DATE OF DEATH Month Day Year DEC. 4 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 18, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYE OF ROSENBAUM'S INC.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	9. AGE (In years last birthday) 75
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? MARYLAND	
13. FATHER'S NAME GEORGE W. CROMWELL		14. MOTHER'S MAIDEN NAME MARGARET A. HOWELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-8275	
17. INFORMANT PATIENT C HART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Essential Hypertension DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCTOBER, 1960 to 4 Dec , 19 61 , that (I) (we) last saw the deceased alive on 3 DEC , 19 61 , and that death occurred at 5:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Louis Michael Glick M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Michael Glick		22d. ADDRESS 126 N. Smallwood St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/61	
23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR DEC 7 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CENTRAL BANK OF DENMARK

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13311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film G304 1/4/62 iwk

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

FROSTBURG

c. LENGTH OF STAY IN

D.O.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MARYLAND

b. COUNTY ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X R.F.D.1, FROSTBURG,

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MINERS HOSPITAL

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

MARSHALL

Middle

ALLEN

Last

CROSTON

4. DATE
OF
DEATH

Month

DECEMBER

Day

23RD,

Year

19 61

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1904 MARCH 21ST, 1903

9. AGE (In years
last birthday)

57 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

TAXI DRIVER

10b. KIND OF BUSINESS OR INDUSTRY

TAXI BUSINESS

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES E. CROSTON

14. MOTHER'S MAIDEN NAME

CARRY MURPHY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-01-8801

17. INFORMANT

Address

MRS. MAY CROSTON, R.F.D.1, FROSTBURG, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

PULMONARY EDEMA, HYDROTHERAX

INTERVAL BETWEEN
ONSET AND DEATH
HOURS

420-1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

CHRONIC MYOCARDITIS

DUE TO

(c)

CORONARY SCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

PORTAL CIRRHOSIS

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour
o. m.
p. m.

19

20d. INJURY OCCURRED

While
of work ☐ Not while
of work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my
opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

W O McLane

M.D. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

12/23/61

EXAMINER'S
NAME (Type)

W. O. McLANE

Asst. DEPUTY MEDICAL EXAMINER ☒22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

12-26-61

22c. NAME OF CEMETERY OR CREMATORY

F'BG. MEMORIAL PARK

22d. LOCATION (City, town, or county)

FROSTBURG,

(State)

MD.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

FROSTBURG, MD.

24a. REC'D BY REGISTRAR

DATE DEC 27 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
DEATH

12345

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased	
2. Sex	
3. Age	
4. Date of death	
5. Place of death	
6. Cause of death	
7. Manner of death	
8. Signature of medical examiner	
9. Signature of physician	
10. Signature of coroner	
11. Signature of registrar	
12. Signature of funeral director	
13. Signature of next of kin	
14. Signature of witnesses	
15. Signature of jury	
16. Signature of coroner	
17. Signature of registrar	
18. Signature of funeral director	
19. Signature of next of kin	
20. Signature of witnesses	
21. Signature of jury	
22. Signature of coroner	
23. Signature of registrar	
24. Signature of funeral director	
25. Signature of next of kin	
26. Signature of witnesses	
27. Signature of jury	
28. Signature of coroner	
29. Signature of registrar	
30. Signature of funeral director	
31. Signature of next of kin	
32. Signature of witnesses	
33. Signature of jury	
34. Signature of coroner	
35. Signature of registrar	
36. Signature of funeral director	
37. Signature of next of kin	
38. Signature of witnesses	
39. Signature of jury	
40. Signature of coroner	
41. Signature of registrar	
42. Signature of funeral director	
43. Signature of next of kin	
44. Signature of witnesses	
45. Signature of jury	
46. Signature of coroner	
47. Signature of registrar	
48. Signature of funeral director	
49. Signature of next of kin	
50. Signature of witnesses	
51. Signature of jury	
52. Signature of coroner	
53. Signature of registrar	
54. Signature of funeral director	
55. Signature of next of kin	
56. Signature of witnesses	
57. Signature of jury	
58. Signature of coroner	
59. Signature of registrar	
60. Signature of funeral director	
61. Signature of next of kin	
62. Signature of witnesses	
63. Signature of jury	
64. Signature of coroner	
65. Signature of registrar	
66. Signature of funeral director	
67. Signature of next of kin	
68. Signature of witnesses	
69. Signature of jury	
70. Signature of coroner	
71. Signature of registrar	
72. Signature of funeral director	
73. Signature of next of kin	
74. Signature of witnesses	
75. Signature of jury	
76. Signature of coroner	
77. Signature of registrar	
78. Signature of funeral director	
79. Signature of next of kin	
80. Signature of witnesses	
81. Signature of jury	
82. Signature of coroner	
83. Signature of registrar	
84. Signature of funeral director	
85. Signature of next of kin	
86. Signature of witnesses	
87. Signature of jury	
88. Signature of coroner	
89. Signature of registrar	
90. Signature of funeral director	
91. Signature of next of kin	
92. Signature of witnesses	
93. Signature of jury	
94. Signature of coroner	
95. Signature of registrar	
96. Signature of funeral director	
97. Signature of next of kin	
98. Signature of witnesses	
99. Signature of jury	
100. Signature of coroner	

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 60 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION WARWICK & MEMORIAL MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, ROUTE # 5 d. STREET ADDRESS Cresaptown, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MITCHELL WAYNE CUTCHALL		4. DATE OF DEATH Month DECEMBER Day 16 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/61
9. AGE (In years last birthday) yrs. 7		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None- Infant		11b. KIND OF BUSINESS OR INDUSTRY None	
12a. CITIZENSHIP (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WALTER CUTCHALL JR.		14. MOTHER'S MAIDEN NAME SHIRLEY A. KIRK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALINE Membrane Disease - Lungs 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atelectasis DUE TO (c) Prematurity (7mo. gestation) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 days 7 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 10, 1961 , to Dec. 16, 1961 , that (I) (we) last saw the deceased alive on Dec. 16, 1961 , and that death occurred at 9:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Ralph A. Reiter M.D.		22b. DATE SIGNED 12/17/61	
22c. PHYSICIAN'S NAME (Type) DR. RALPH REITER		22d. ADDRESS 112 BEDFORD ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 18, 1961	
23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		23d. LOCATION (City, town or county) (State) Nr. Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thoma			

2060232XV2



11312

ALLEGANY

CLEVELAND, OH.

WALKER & COMPANY

WES.

MEMORIAL HOSPITAL

Cross to H.

OUTPATIENT

DECEMBER 10, 1911

11312

CLEVELAND, OH.

Home

Home - 11312

WALTER CLEVELAND JR.

SHIRLEY A. WALKER

MEMORIAL HOSPITAL CLEVELAND, OH.

Home

NO

HYALINE Membrane Disease - lungs

6 days
7 days

Atelectasis
Pneumonia

(transpiration)

Dec 12 1911

Dec 12 1911

WALKER & COMPANY

DR. RALPH WALKER

11312

11312

11312

11312

Charles L. George, Cleveland, OH.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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13313

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13295

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/27/1956	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 200 Avirett Avenue	
3. NAME OF DECEASED (Type or print) First Ada Middle Ethel Last Dahl		4. DATE OF DEATH Month December Day 15 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Rice		14. MOTHER'S MAIDEN NAME Sarah Newell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599, Allegany County Infirmary records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy - 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis & hypertension (c) Heemic plegia, Rt side		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/27/56 to 12/15/61 that (I) (we) last saw the deceased alive on 12/15/61 @ 7:30 P.M. and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews M.D.		22b. DATE SIGNED 12/16/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I2-I8-6I	
23c. NAME OF CEMETERY OR CREMATORY St Mary Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 22 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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1951

CENTRAL AIR FORCE

1951

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15/12/51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13296

13314

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Vale.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 517 Nat. Hwy.				d. STREET ADDRESS 517 Nat. Hwy.			
3. NAME OF DECEASED (Type or print) First CLAUDE Middle LENHART Last DEAL				4. DATE OF DEATH Month Dec. Day 26 , Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1899		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Whsl. Oil Dlr.		10b. KIND OF BUSINESS OR INDUSTRY Oil Bus.		11. BIRTHPLACE (State or foreign country) Meyersdale, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Calvin E. Deal				14. MOTHER'S MAIDEN NAME Margaret Lenhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W.W. # 1		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Margaret Deal, 517 Nat. Hwy. La Vale Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF HEAD OF PANCREAS WITH WIDESPREAD LIVER METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERY SCLEROSIS: HYDROTHORAX							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/26/61			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Rt. # 9 Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/61		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery,		22d. LOCATION (City, town, or county) (State) Meyersdale, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 29 '61	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF REVENUE - BALTIMORE, MD

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
13315														
13297														
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 41 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEDFORD d. STREET ADDRESS Route 3, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) OLIVER W DEIHL					4. DATE OF DEATH Month DEC. Day 27 Year 1961									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 6, 1875		9. AGE (In years last birthday) 86 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (County & State, or foreign country) GILPIN TOWN, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME BERNARD DEIHL					14. MOTHER'S MAIDEN NAME EMMA FETTERS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 216-10-9280					17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Part II Fracture closed intertrochanteric Left thigh PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home on 11-14-61 sustaining Fracture intertrochanteric Left thigh 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										INTERVAL BETWEEN ONSET AND DEATH 43 days				
21. I certify that (I) (this hospital) attended the deceased from 11-16- to 12-27- 19 61 , that (I) (we) last saw the deceased alive on 12-27 19 61 , and that death occurred on 12-28 P.M. from the causes and on the date stated above.														
22a. SIGNATURE William R. Wolverton M.D. 22c. PHYSICIAN'S NAME (Type) DR. WILLIAM R. WOLVERTON M. D.					22b. DATE SIGNED 12-30-61 22d. ADDRESS 108 HARRISON ST. CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 12/30/61					23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park Cumberland Md				
24. FUNERAL DIRECTOR'S SIGNATURE Byron Light					25a. REC'D BY REGISTRAR DATE JAN 2 '62					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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13315



ALCOHOL

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FOR STATE
HEALTH DEPT.
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TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13316

13298

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA MEMORIAL HOSPITAL			d. STREET ADDRESS 696 FAYETTE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last F. HARRY F. DIXON			4. DATE OF DEATH Month Day Year DEC. 11 19 61		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 2, 1903	9. AGE (In years last birthday) 58 yrs.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAOD FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME ROBERT J. DIXON (D)		
14. MOTHER'S MAIDEN NAME SARA F. BAUGHMAN (D)			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		
16. SOCIAL SECURITY NO. 705 10 8455			17. INFORMANT Address MRS. JESSIE DIXON CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY SCLEROSIS WITH THROMBOSIS, RT. RECENT DUE TO Conditions, if any, which gave rise to immediate cause (b) MYOCARDIAL INFARCTION WITH ANEURYSM, LEFT. OLD (a), stating the underlying cause last. (c) CORONARY SCLEROSIS WITH OCCLUSION					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED DECEMBER 11, 1961					
EXAMINER'S SIGNATURE Benedict Skitarelic M.D. NAME (Type) BENEDICT SKITARELIC, M.D. Address (Street, city, town, or county) R 9, Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 14, 1961		22c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	
22d. LOCATION (City, town, or country) CUMBERLAND, MD.		(State)			
23. FUNERAL DIRECTOR ADDRESS BYRON KIGHT CUMBERLAND, MD.					
24a. REC'D BY REGISTRAR DEC 15 61					
24b. REGISTRAR'S SIGNATURE <i>Carlton S. Haines</i>					

10318

(1)

Handwritten signature

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13299

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN b 18 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN d. STREET ADDRESS Rt. # 5 Brant Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAVINIA MAE DOUTHITT		4. DATE OF DEATH Month DECEMBER Day 1 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 26, 1918 43
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND, Allegany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HARRY C. CECIL		14. MOTHER'S MAIDEN NAME MARY E. STOTTLEMYER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Charles Douthitt Rt. 5 Cresaptown, Md.	
17. INFORMANT Charles Douthitt Rt. 5 Cresaptown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lungs (Metastatic) DUE TO (b) Adeno-Carcinoma Breast DUE TO (c) 170 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19....., to 19....., that (I) (we) last saw the deceased alive on 19....., and that death occurred at 1:30 PM on the causes and on the date stated above.			
22a. SIGNATURE Dr. F. B. Whitworth M.D.		22b. DATE SIGNED 12/4/61	
22c. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH		22d. ADDRESS 123 BEDFORD ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/61	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,		25a. REC'D BY REGISTRAR DEC 5 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	



113317

18 DAYS

MEMORIAL HOSPITAL
HARRICK & MEMORIAL AVENUES

LAVINIA

WHITE

CRIME OF MURDER

MARY C. BUCH

MARYLAND

CRESSKENTON

113317

WILLIAM

DECEMBER 11, 1911

MARYLAND, 113317

MARY C. BUCH

Carroll County, Maryland
113317

DR. J. S. WHITMORT

113317

113317

113317

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13318					13300				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Allegany			STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lonaconing			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lonaconing		
c. LENGTH OF STAY IN 1b		69yrs.			d. STREET ADDRESS		East Main Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		East Main Street			a. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First ROBERT					Last DOYLE				
5. SEX					6. COLOR OR RACE				
Male					white				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					12/1/1892				
9. AGE (In years last birthday)					69 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
Retired Celanese Corp/					Lonaconing, MD.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Robert Doyle					Annie Simpson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.				
No					217-10-6054				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					Cerebral Thrombosis (WIFE)				
DUE TO					332 X				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					DUE TO				
					Arteriosclerosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH				
					1 hour				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
Hour a.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July 1956 to Dec. 1961, that (I) (we) last saw the deceased alive on Dec. 20, 1961, and that death occurred at 9 A.M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
L.R. MILES, JR., M.D.					1-2-62				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
L.R. MILES, JR., M.D.					LONA CONING MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF				
Burial					1/2/1962				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)				
MEMORIAL PARK					FROSTBURG, MD.				
24 FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR				
GEORGE EICHHORN					DATE JAN 4 '62				
25b. REGISTRAR'S SIGNATURE									
LONA CONING, MD.					L. K. Kline				

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13319

CERTIFICATE OF DEATH

13301

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN lb 11Ds. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital			2. USUAL RESIDENCE (Where deceased lived, If Institutions: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport d. STREET ADDRESS 118 Waverly e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Michael First Middle Last S. Duckworth			4. DATE OF DEATH Month Day Year Dec. 9 1961		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 6, 1879		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George M. Duckworth			
14. MOTHER'S MAIDEN NAME Mary Ann ' Duckworth'		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO. 236-01-8061		17. INFORMANT Address Mrs. Marie Dubois-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Vascular Accident (c) Arteriosclerotic Heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 days 16 days 15 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-27 , 19 61 , to 12-9-61 , 19 61 , that (I) (we) last saw the deceased alive on 12-9-61 , 19 61 , and that death occurred at 7:44 AM, from the causes and on the date stated above.					
22a. SIGNATURE William W. Lesh M.D.		22b. DATE SIGNED 12-11-61		22c. PHYSICIAN'S NAME (Type) William W. Lesh	
22d. ADDRESS Westernport, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 12/11/61		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Ed. Bual ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE DEC 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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100-57-32

• BM, J. G. G. G. G.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13320 CERTIFICATE OF DEATH 13302

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b D O A	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
f. STREET ADDRESS 306 E. MAIN ST.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRENE		4. DATE OF DEATH Month DEC. Day 9, Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 17, 1891
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSING	
11b. KIND OF BUSINESS OR INDUSTRY MINERS HOSPITAL		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANDREW J. WILLIAMS	
14. MOTHER'S MAIDEN NAME MARY ANN EVANS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) WW 1	
16. SOCIAL SECURITY NO. WW 1		17. INFORMANT MRS. HARRY W. BAKER, FROSTBURG, MD.	
18. CAUSE OF DEATH [Enter only one cause and line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Sclerosis DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 14 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 8 '61 to Dec 9 '61 , that (I) (we) last saw the deceased alive on Dec 8 '61 , and that death occurred Dec 9 '61 from the causes and on the date stated above.			
22a. SIGNATURE W. O. McLane		22b. DATE SIGNED Dec 11 '61	
22c. PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-12-61	
23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Duvet		25a. REC'D BY REGISTRAR DEC 14 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

13302

13302



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TO HOSPITAL
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13321

13303

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT 85K-3 d. STREET ADDRESS 37 E. HAMPSHIRE STREET a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HERBERT V. FISHER First Middle Last 4. DATE OF DEATH DECEMBER 19 19 61 Month Day Year				5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JAN. 21, 1885 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telegrapher 10b. KIND OF BUSINESS OR INDUSTRY B&O R. R. CO. 11. BIRTHPLACE (County & State, or foreign country) MOOREFIELD, W.VA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CHARLES FISHER 14. MOTHER'S MAIDEN NAME TURLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 465 X Pulmonary Embolism IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Suprapubic proctostomy INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 9, 1961, to Dec 19, 1961, that (I) (we) last saw the deceased alive on Dec 19, 1961, and that death occurred 8:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Walter N. Himmler M.D. 22c. PHYSICIAN'S NAME (Type) WALTER N. HIMMLER				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 412 N. MECHANIC ST., CUMBERLAND, MD.		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. N. Friedrichs for Piedmont W. Va. ADDRESS				25a. REC'D BY REGISTRAR DEC 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1933



ALLEGANY

WEST VIRGINIA

MINERAL

COMBINED

10 DAYS

10 DAYS

MEMORIAL HOSPITAL

37 E. WASHINGTON ST.

HERBERT

HERBERT

DECEMBER 19

WHITE

WHITE

WHITE

CHARLES FISHER

THURSDAY

MEMORIAL HOSPITAL

COMBINED

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DEC 11 1933

DEC 11 1933

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WALTER A. HINCHER

HIS B. RECHNITS ST., COMBINED

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13322

CERTIFICATE OF DEATH

13304

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY GREENSPRING		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 85X-3		d. STREET ADDRESS MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NELLIE		First R.		Middle FOLEY		Last FOLEY		4. DATE OF DEATH Month DECEMBER 13,		Day 1961		Year 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-3-1903		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58		IF UNDER 24 HRS. Days 58		Hours 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) SPRINGFIELD, W. VA.				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME JOHN CROCK						14. MOTHER'S MAIDEN NAME SUSAN KERNS											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes give number or dates of service)		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.						Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, acute, monocytic 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH 1 month			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 8 Dec. 1961 9:50 P.M. 13 Dec., 1961 that (I) (we) last saw the deceased alive on 13 Dec. 1961 and that death occurred at M. from the causes and on the date stated above.																	
22a. SIGNATURE W. Alfred Van Ormer				M.D. W. A. VAN ORMER		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 15 Dec. 61									
22c. PHYSICIAN'S NAME (Type) DR. EARL R. XXXXX				22d. ADDRESS 122 S. CENTRE STREET. GREENSPRING, CUMBERLAND, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 16, 1961		23c. NAME OF CEMETERY OR CREMATORY Forest Glenn Cemetery		23d. LOCATION (City, town or county) Greenspring		(State) W. Va.							
24. FUNERAL DIRECTOR'S SIGNATURE Robert Hoffman				ADDRESS Romney W. Va.		25a. REC'D BY REGISTRAR DEC 22 '61		25b. REGISTRAR'S SIGNATURE Robert S. Thomas									

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ALLGANY

CUMERLAND

REHABILITATION & NURSING CENTER
MEMORIAL HOSPITAL

WHITE

WHITE

JOHN CRICK

WEST VIRGINIA

GREENSBORO

DAYS

FOLEY

1-1-1903

SUBAN HARTS

MEMORIAL HOSPITAL - GREENSBORO, W. VA.

DR. ROBERT W. W. VAN COTT
182 S. L. THE STREET

10011 Dec 1941 For est. Green County
10011 Dec 1941 For est. Green County

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13305

FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If at any time the day is not a day, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b 3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 146 POLK STREET	
3. NAME OF DECEASED (Type or print) First ELMER Middle ELSWORTH Last FORD				4. DATE OF DEATH Month DECEMBER Day 18 Year 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 10, 1907		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 54 Days 18 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman Helper		10b. KIND OF BUSINESS OR INDUSTRY B & O R. R.		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR FORD (Deceased)				14. MOTHER'S MAIDEN NAME FLORENCE BOURN (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 420.1		17. INFORMANT Mrs. Clara Ford		18. ADDRESS 146 Polk Street, Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, LEFT DUE TO (b) CORONARY SCLEROSIS WITH THROMBOSIS (ALSO MYOCARDIAL INFARCTION, LEFT) DUE TO (c) RECENT							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF 12/21/61		22c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery		22d. LOCATION (City, town, or country) Vermillion Ohio		18 DATE SIGNED DECEMBER 18, 1961	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery		22d. LOCATION (City, town, or country) Vermillion Ohio		24a. REC'D BY REGISTRAR DEC 20 '61	
23. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS 404 Decatur Street, Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE Anthony S. Kraus			

THE STATE
NEW YORK

(M)

(1)

COMMONLY KNOWN AS
COMMONLY KNOWN AS
(ALSO KNOWN AS)

Handwritten signature

RECEIVED SET-UP

1. Two copies

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13324

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. No. 10806

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 813 Edgewood Drive				d. STREET ADDRESS 813 Edgewood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANE Middle FROEHLICH Last FROEHLICH				4. DATE OF DEATH Month Dec. Day 5, Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1893	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John McCrorie				14. MOTHER'S MAIDEN NAME Margaret Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Margaret Pownall Address Cumberland, Md. 813 Edgewood Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) SUDDEN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 5, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/61		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR DEC 7 '61		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the medical examiner. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. These pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13325					13307				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Allegany MARYLAND					a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) "Rural" Frostburg				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital					d. STREET ADDRESS 1				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED			4. DATE OF DEATH						
(Type or print)									
Emma			Green			December 10 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		January 6, 1896		65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
House Work		Own Home		Midland, Maryland		U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Charles Dawson					Spiker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no					16. SOCIAL SECURITY NO.				
					17. INFORMANT				
					Address				
					Arch Green Gilmore, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					6 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X				
20c. TIME OF INJURY Month, Day, Year Hour a.m. X p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12/9 19 61 to 12/10 19 61 that (I) (we) last saw the deceased alive on 12/10 19 61 , and that death occurred at 3 M, from the causes and on the date stated above.									
22a. SIGNATURE Martin M. Rothstein M.D.					22b. DATE SIGNED 12/11/61				
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.					22d. ADDRESS 48 BROADWAY - FROSTBURG - MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			12/13/61		Old Coney Cemetery		Lonaconing, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR				
George Eichhorn					DEC 13 '61				
ADDRESS Lonaconing, Md.					25b. REGISTRAR'S SIGNATURE Arthur L. Kraus				

2525

George B. Johnson

• **Intelligence**

TO HOSPITAL: The law requires that the death certificate be executed within 60 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13326

13308

Item 7 Film G305 1/8/62

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN b 16 DAYS		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, MARYLAND		d. STREET ADDRESS 1 1614 FORD AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIRGIE		First MARY		Middle HAINES		Last HAINES		4. DATE OF DEATH Month DECEMBER		Day 31		Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH AUG. 14, 1910		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 31		Days 19		IF UNDER 24 HRS. Hours 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner & Prop. Restaurant		10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME JOHN HAINES		14. MOTHER'S MAIDEN NAME Mollie Hott													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 220-10-8860		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND MD.		Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Rupture Bl Vessel from stress vomiting DUE TO (b) (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 16 days		INTERVAL BETWEEN ONSET AND DEATH 16 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12/15/61		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) Cumberland, Md.		(County) Allegany		(State) Md.					
21. I certify that (I) (this hospital) attended the deceased from 12/15/61 to 12/31/61 , 19 61 , that (I) (we) last saw the deceased alive on 12/30/61 , 19 61 , and that death occurred at 7:20M , from the causes and on the date stated above.															
22a. SIGNATURE DR. R. J. WILLIAMS		22b. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22c. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.		22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.		22e. DATE 1/1/62		22f. SIGNATURE Arthur L. Hous					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/62		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City, town or county) Cumberland, Md.		23e. (State) Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 4 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hous									



ALLEGEDLY

MEMORIAL HOSPITAL
WARRINGTON & MEMORIAL
CUNNINGHAM, MD.

12 DAYS
WARRINGTON & MEMORIAL
WARRINGTON & MEMORIAL

WHITE

WHITE

JOHN HINES

WEST VIRGINIA

AUG. 17, 1910

WEST VIRGINIA

MEMORIAL HOSPITAL, WARRINGTON, D.

DR. R. J. WILLIAMS

125 S. CENTRE ST., WARRINGTON, D.

CHARLES D. GEORGE, M.D.

WARRINGTON, D.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13309

1. PLACE OF DEATH a. COUNTY ALLEGANY										2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND										b. COUNTY ALLEGANY																																																																															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland										c. LENGTH OF STAY IN lb Life										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland										d. STREET ADDRESS 8 Marion Street										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8 Marion Street										3. NAME OF DECEASED (Type or print) James Carroll Hammond										4. DATE OF DEATH Month December Day 6 Year 1961										5. SEX Male										6. COLOR OR RACE White										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH Oct 8, 1941										9. AGE (In years last birthday) 20 yrs.										IF UNDER 1 YEAR Months 20 Days 20										IF UNDER 24 HRS. Hours 20 Min. 20									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caddy, Country Club										10b. KIND OF BUSINESS OR INDUSTRY Caddy, C. Club										11. BIRTHPLACE (State or foreign country) Cumberland, Maryland										12. CITIZEN OF WHAT COUNTRY? U. S. A.										13. FATHER'S NAME Leo Robert Hammond										14. MOTHER'S MAIDEN NAME Nora Virginia Simmons																																																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No										16. SOCIAL SECURITY NO. 214-42-0278										17. INFORMANT Mr. Leo R. Hammond										Address 8 Marion Street										18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) GUN SHOT WOUND OF CHEST 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH SUDDEN																																																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)																													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER Benedict Skitarellic M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										DATE SIGNED Dec 6, 1961																																																											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 12/8/61										22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park										22d. LOCATION (City, town, or country) (State) Cumberland, Maryland										23. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland										24a. REC'D BY REGISTRAR DEC 11 '61										24b. REGISTRAR'S SIGNATURE Arthur S. Kraus																																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page _____ may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13328

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 430 VIRGINIA AVE.	
3. NAME OF DECEASED (Type or print) JESSIE Elizabeth HEFNER		4. DATE OF DEATH 12 28 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE (In years last birthday) 64 yrs.
11. BIRTHPLACE (County & State, or foreign country) Oldtown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN Nixon		14. MOTHER'S MAIDEN NAME RUTH ANN Seaton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wm. J. Hefner		Address 430 Va. Ave., Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Ca of colon to brain 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Ca of Colon (c) gloma		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 7 1961 to 1/12/61 , that (I) (we) last saw the deceased alive on 1/7/61 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. B. SCHINDLER		22b. DATE SIGNED 1/14/61	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS 43 GREENE ST Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/61	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR JAN 2 '62	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

ES61

13353

ALLGAY

MARYLAND

ALLGAY

CUMBERLAND

7 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

BOY

BOY

DEC. 21, 1961

WHITE

12-21-61

WHITE

CUMBERLAND

M. S. S.

JAMES C. HERSHBERGER

HELEN A. SWANER

BOY

MEMORIAL HOSPITAL - CUMBERLAND, MD.

*Government
Service Information*

30 P.M.

DR. W. ROYCE HODGES

122 S. CENTRE ST., CUMBERLAND, MD.

James J. Scarpelli, Esq.
12-21-61
CUMBERLAND, MD.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DR. HASHIM

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13330

13312

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE CUMBERLAND, MD. b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 1600 VIRGINIA AVE., CUMBERLAND, MD. d. STREET ADDRESS 1 1600 Virginia Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL JOSEPH First Middle Last HORWATH		4. DATE OF DEATH Month Day Year DECEMBER 29 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-57
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months Days 4 Months 29 Days	11. IF UNDER 24 HRS. Hours Min. 19 Hours 61 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HORWATH, JOHN		14. MOTHER'S MAIDEN NAME BRANT, MARY J.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia with Hyperpyrexia DUE TO (b) Gastro-Enteritis DUE TO (c) Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Anystonia Congenita PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anystonia Congenita INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from DEC. 22 1961 to DEC. 29 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Hashim M.D.		22b. DATE SIGNED DEC. 29 1961	
22c. PHYSICIAN'S NAME (Type) DR. HASHIM		22d. ADDRESS 20 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-I-62	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13331
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
13313

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 423 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sallie Middle House Last House		4. DATE OF DEATH Month Dec. Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1886
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boarding House		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (State or foreign country) Great Capon, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Holliday		14. MOTHER'S MAIDEN NAME Virginia Bohrer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Franklin House, Baltimore, Md.	
17. INFORMANT Franklin House, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarellic		DATE SIGNED December 23, 1961	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) R9 Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 26, 1961	
22c. NAME OF CEMETERY OR CREMATORY Camp Hill		22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.	
23. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DEC 28 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

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FEB 10 1964

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COMPANY OF AMERICA

CONTRACT NO. 10000

Handwritten signature

W. H. WILSON, JR.

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FOR STATE
HEALTH DEPT.

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the funeral director. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13332

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13314

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)							
3. NAME OF DECEASED (Type or print) Francis Hughes				4. DATE OF DEATH Month December Day 31 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 11, 1920	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 11 Hours 11 Min.		11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mine			
13. FATHER'S NAME John F. Hughes				14. MOTHER'S MAIDEN NAME Annie McGowan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) 2nd W. War				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Helen Hughes Address Midland, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY "Wife" OCCLUSION Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS WITH THROMBOSIS (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21. ACTUAL SIGNATURE WOMcLane MD				21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
21. EXAMINER'S NAME (Type) WOMcLane MD				21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				21. DATE SIGNED 12/31/61			
21. Address (Street, city, town, or county) Frostburg, Md.				22a. BURIAL, CREMATION, or other disposition (Specify) Burial			
22b. DATE THEREOF 1/3/62				22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery			
22d. LOCATION (City, town, or country) (State) Frostburg, Md.				23. FUNERAL DIRECTOR George Eichhorn ADDRESS Lonaconing, Md.			
24a. REC'D BY REGISTRAR JAN 3 '62				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13333

13315

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 12/9/1961		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 534 Necessity Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Humbertson		4. DATE OF DEATH Month December Day 11, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Salem Humbertson		14. MOTHER'S MAIDEN NAME Agnes Koontz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-10-7873	
17. INFORMANT P.O. Box 599 Allegany County Infirmary records.		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Myocardial Infarction, Senile DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis, degenerative DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/9/61 19... to 12/11/61 19... that (I) (we) last saw the deceased alive on 12/9/61 19... and that death occurred at... M., from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews M.D.		22b. DATE SIGNED 12/11/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/61	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		25a. REC'D BY REGISTRAR DATE DEC 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			



12/31/61

Allegany

12/31/61

Allegany County Jail

Allegany County Jail

George

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Retired: Lector

Lector

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Allegany County Jail

Allegany County Jail

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, delay is necessary. Page 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13316											
1. PLACE OF DEATH a. COUNTY Allegany						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland,				d. STREET ADDRESS 111 South St.,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 111 South St.,						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FLORENCE			First BELLE			Middle ISNER			Last		
4. DATE OF DEATH Dec. 25, 1961			Month			Day			Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 25, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home				11. BIRTHPLACE (State or foreign country) Bowden, W. Va.			
12. CITIZEN OF WHAT COUNTRY U. S. A.				13. FATHER'S NAME John W. Day				14. MOTHER'S MAIDEN NAME Sarah Summerfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.				16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. Martin L. Isner 111 So. St., Cumb. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO CORONARY SCLEROSIS										INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			December 25, 1961		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/27/61		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				22d. LOCATION (City, town, or country) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR Charles L. George						ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DEC 28 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kram</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13335
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
14649

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4/4/1960	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 65 E. Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Jackson		4. DATE OF DEATH Month December Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1883
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Lumberjack		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Jackson		14. MOTHER'S MAIDEN NAME Mary Ines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-03-9869	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 <i>Myocardial infarction, decomposing</i> DUE TO <i>arterio-sclerosis & cerebral arteriosclerosis</i> (b) <i>cerebral apoplexy, left hemiplegia</i> DUE TO <i>Diabetes mellitus</i> (c) <i>Diabetes mellitus</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/4/1960 to 12-30 , 19 66 , that (I) (we) last saw the deceased alive on 12/30/66 at 11:40 P.M. , and that death occurred at 12/30/66 from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 1/1/62	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/62	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Boyle & Houtz		25a. REC'D BY REGISTRAR JAN 9 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13317

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R. 1, FROSTBURG				c. LENGTH OF STAY IN 1b 45 YRS.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X R. R. 1, FROSTBURG (BOX 183)			
				d. STREET ADDRESS 1			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EMIL P. KAMAUF				4. DATE OF DEATH Month Day Year December 13 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 9TH, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. *COAL MINER				10b. KIND OF BUSINESS OR INDUSTRY COAL MINING		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME CONRAD KAMAUF				14. MOTHER'S MAIDEN NAME ELIZABETH KUCKENBISER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 214-01-3771			
				17. INFORMANT Address BOX 183 MRS. EMIL KAMAUF, RT. 1, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic C-v disease (c) Generalized Arteriosclerosis DUE TO Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gouty arthritis 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 6/12, 1951 , to 12/9, 1961 , that (I) (was) last saw the deceased alive on 12/9, 1961 , and that death occurred at 7:22 M, from the causes and on the date stated above. 22a. SIGNATURE Frank T. Harrat M.D. 22b. DATE SIGNED 12/14/61 22c. PHYSICIAN'S NAME (Type) F. T. HARRAT 22d. ADDRESS 26 W. MECHANIC ST., FROSTBURG, MD. 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 12-15-61 23c. NAME OF CEMETERY OR CREMATION ZION UNITED C.O.F.C. 23d. LOCATION (City, town or county) (State) FROSTBURG, MD. 24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst ADDRESS FROSTBURG, MD. 25a. REC'D BY REGISTRAR DEC 18 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 48 HOURS AFTER THE DEATH. IT MUST BE SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

5/12/2011

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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13318

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cresaptown,			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hosp.				d. STREET ADDRESS 6th Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Earl Middle Russell Last Kitzmiller				4. DATE OF DEATH Month Dec. Day 28, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1902	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 59 Days 59	IF UNDER 24 HRS. Hours 59 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Super market		11. BIRTHPLACE (State or foreign country) Kitzmiller, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clayton Kitzmiller				14. MOTHER'S MAIDEN NAME Maude Harvey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 232-10-2761		17. INFORMANT Mrs. Mildred Kitzmiller, Cresaptown, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION, RIGHT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY ATHEROSCLEROSIS WITH THROMBOSIS (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ALSO MYOCARDIAL HYPERTROPHY, MARKED						INTERVAL BETWEEN ONSET AND DEATH 12 Hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DECEMBER 28, 1961 Address (Street, city, town, or county) R9, Cumberland, Md. DATE SIGNED							
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/61		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens, Cumberland, Md.		22d. LOCATION (City, town, or county) (State) R9, Cumberland, Md.	
23. FUNERAL DIRECTOR Charles L. George Cumberland, Md. ADDRESS				24a. REC'D BY REGISTRAR JAN 2 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



Handwritten signature

1/11/11

James L. George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale Rural Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 228 National Highway	
3. NAME OF DECEASED (Type or print) Anna First Viola Middle Lee Last		4. DATE OF DEATH 12 - 15 19 61 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) PA.
13. FATHER'S NAME John H. Bisel		14. MOTHER'S MAIDEN NAME Anne W. Wingert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Chart Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 4 3 Branchopneumonia, terminal type DUE TO (b) 4 4 3 Congestive Heart Failure DUE TO (c) 4 4 3 Hypertensive & Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro-vascular disease & old Rt Cerebral Infarction			INTERVAL BETWEEN ONSET AND DEATH 3 days 45 days 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 12/15/61 to 12/15/61 ; that (I) (we) last saw the deceased alive on 12/15/61 , and that death occurred at 6:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. S. Weisman M.D.		22b. DATE SIGNED 12/16/61	
22c. PHYSICIAN'S NAME (Type) Dr. S. Weisman		22d. ADDRESS 59 Greene Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 18, 1961	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Pauls	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland		25a. REC'D BY REGISTRAR DEC 20 1961	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13320

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>82 Cumberland,</u>		d. STREET ADDRESS <u>613 Henderson Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>613 Henderson Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cindie</u> Middle <u>Lepley</u> Last <u>Lepley</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>19 61</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 16, 1880</u>	
9. AGE (In years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Whittenberg, Pennsylvania</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Owen Murray</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Saylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Adam G. Lepley</u>	
				Address <u>613 Henderson Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
						<u>unknown</u>	
						<u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dissecting aortic aneurysm</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10 Nov</u> 19 <u>61</u> to <u>15 Dec</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>17 Nov</u> 19 <u>61</u> , and that death occurred at <u>8:30 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>David T. Rees</u>				22b. DATE SIGNED <u>16 Dec 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>DAVID T. REES</u>				22d. ADDRESS <u>101 MONTGOMERY AVE. CUMBERLAND, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Savage Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Mt. Savage, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>				ADDRESS <u>Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 22 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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James H. ...

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13321

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TINA</u> Middle <u>MARIE</u> Last <u>LEWIS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Welsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John Lewis, Consolidation Village,</u>		Address <u>Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Polmonary Hemorrhage</u> <u>881.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Polmonary Edema</u> (c) <u>2 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>Child Swallowed Cigarette Lighter Fluid</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Dec 21 1961</u> Hour <u>9:30</u> a.m. <u>9</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Frostburg Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W O McLane</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W O McLane</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Frostburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> <u>Boulah H. Montecary</u>		24a. REC'D BY REGISTRAR <u>DEC 27 '61</u>	
ADDRESS <u>23 E. Main, Frostburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Kanne</u>	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13341
CERTIFICATE OF DEATH
13322

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. #5, CUMBERLAND		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM T. LEWIS		4. DATE OF DEATH DECEMBER 14, 1961							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-10-1879		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME EDWARD LEWIS		14. MOTHER'S MAIDEN NAME MARY THOMAS							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dec 12 61		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 14 61 to Dec 14 61 , that (I) (we) last saw the deceased alive on Dec 14 61 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.		22a. SIGNATURE Dr. S. G. Weisman		M.D. Dr. S. G. Weisman		22b. ADDRESS 59 GREENE ST., CUMBERLAND, MD.		22c. DATE SIGNED 12/16/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/61		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.		23d. LOCATION (City, town or county) Frostburg Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Hafer		ADDRESS Cumberland Md		25a. REC'D BY REGISTRAR DEC 22 '61		25b. REGISTRAR'S SIGNATURE Carroll J. Hinkle			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13323

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown Road			
c. LENGTH OF STAY in 1b Few Hours				d. STREET ADDRESS R.F.D. 4			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle George Last Long, Sr.				4. DATE OF DEATH Month Dec. Day 26 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5, 1911	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Engineer				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Lee Long				14. MOTHER'S MAIDEN NAME Elizabeth Seggie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-09-5246			
17. INFORMANT Mrs. Elizabeth Long, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 Hrs. ----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 26, 1961 Address (Street, city, town, or county) R9 Cumberland, M.D.							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		NAME (Type) BENEDICT SKITARELIC, M.D.		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-1961		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		22d. LOCATION (City, town, or country) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				24. REC'D BY REGISTRAR DEC 29 '61			
24b. REGISTRAR'S SIGNATURE <i>Emilio S. Kraus</i>							

TO: DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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GENERAL IN CHARGE

HYGIENE & DISINFECTION

* * *

Handwritten signature

UNITED STATES

James H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13343

13324

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First OWEN Middle CARL Last LONG			4. DATE OF DEATH Month DEC. Day 7 Year 19 61		
5. SEX MALE WHITE			6. COLOR OR RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH JAN. 13, 1907 54 yrs.		
9. AGE (In years last birthday) 54			10. IF UNDER 1 YEAR Months 7 Days 19 Hours 61 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEXTILE WORKER			10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		
11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES LONG (DECEASED)			14. MOTHER'S MAIDEN NAME NELLIE BURNS (DECEASED)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 217-10-4888		
17. INFORMANT PATIENTS CHART			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung with metastases DUE TO 163X Conditions, if any, which gave rise to immediate cause (b) to spinal cord column, and compression (c) of spinal cord at cervical level PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 yrs					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 7 Dec 61 to 7 Dec 61 ; that (I) (we) last saw the deceased alive on 7 Dec 19 61 , and that death occurred at 12 M , from the causes and on the date stated above.					
22a. SIGNATURE Heeneesman 22b. DATE SIGNED 12/11/61					
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN 22d. ADDRESS 59 Greene St Cumberland Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/10/61 23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens 23d. LOCATION (City, town or county) (State) Cumberland Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox ADDRESS 404 Decatur Street, Cumberland Maryland 25a. REC'D BY REGISTRAR DATE DEC 14 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hume					

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plus

243. REGISTRAR'S SIGNATURE
Christina L. Kinn



Allegany

Chesapeake Bay

100 Springdale Street

James Elliott

Male

Female

James Lowery

Re

James Lowery

James Lowery

Female

Male

James Elliott

Dec. 2

100 Springdale Street

Chesapeake Bay

Allegany

Dec. 12, 1901

Chesapeake Bay

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13326

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle CATHERINE Last MALLERY		4. DATE OF DEATH Month December Day 18 , Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1876
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Wagner		14. MOTHER'S MAIDEN NAME Sophie Damn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Martha Brant		Address Cumb. Md. 64 N. Mechanic St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (c) --- DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarellic		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> R.D.9 Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/61	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DEC 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

WYOMING STATE DEPARTMENT OF HEALTH-BALTIMORE, IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HRS. 10 MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS 1 LOWER TOWN GREEN ROAD	
3. NAME OF DECEASED (Type or print) LAWRENCE O. MALLERY		4. DATE OF DEATH Month Day Year DECEMBER 19, 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-1864
9. AGE (In years last birthday) 97 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RICHARD MALLERY		14. MOTHER'S MAIDEN NAME ANNIE PITTMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial Failure (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old age (97)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/19/61 , 19 61 , to 12/19/61 , 19 61 , that (I) (we) last saw the deceased alive on 12/19/61 , 19 61 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. RICHARD J. WILLIAMS		22b. DATE SIGNED 12/19/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/61	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		25a. REC'D BY REGISTRAR DATE DEC 22 '61	
ADDRESS Cumberland, Maryland		25b. REGISTRAR'S SIGNATURE Arthur J. Kraus	

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1925-1926

1925

DELAWARE

RICHARD MILBURN

JOHN PITMAN

MEMORIAL HOSPITAL - COVINGTON, LA.

10346

DR. RICHARD J. WILLIAMS

102 S. CENTRAL ST., EVANSTON, ILL.

John F. Hester, Springfield, Ill.

10346

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13347

CERTIFICATE OF DEATH

13328

Item 3, Film G-205 1/24/62, cag.

1. PLACE OF DEATH COUNTY <u>Allegany</u> C <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN b. <u>11</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>408 N Center St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Phyllis Philmino</u> First Middle Last 4. DATE OF DEATH <u>Dec. 30</u> Month Day Year <u>1961</u>					
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1878</u> 9. AGE (In years) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Clerk in Store</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Conrad Wagner</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Hilt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Hospital Chart</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u> DUE TO (b) <u>Myocardial fibrosis; coronary insufficiency</u> (c) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Left ventricular hypertrophy; calcified aorta; mitral stenosis and insufficiency; cardiac decompensation</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>insufficiency; cardiac decompensation</u> 20c. TIME OF INJURY Month, Day, Year <u>19</u> <u>10/16</u> <u>1961</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> , <u>1961</u> , to <u>12/30/61</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12/29/61</u> , 19 <u> </u> , and that death occurred at <u>4:20 A</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel M. Jacobson</u> M.D. 22c. PHYSICIAN'S NAME (Type or print) <u>Samuel M. Jacobson, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>12/30/61</u> 22d. ADDRESS <u>50 Pershing St. Cumberland, Md.</u> 22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 2, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Burial Park</u> 23d. LOCATION (City, town or county) (State) <u>Cumberland</u> <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> <u>Cumberland, Md.</u> ADDRESS <u> </u> 25a. REC'D BY REGISTRAR <u>JAN 5 '62</u> DATE <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hunt</u>			

508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13348

CERTIFICATE OF DEATH

13329

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN lb 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERIA ND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 925 GRAND AVE.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle W. Last MCGRAW	4. DATE OF DEATH Month DEC. Day 2 Year 19 61		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX 4/16/ 1876
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (County & State, or foreign country) ILLINOIS St. Louis
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOSEPH DASHNEY (DECEASED)		14. MOTHER'S MAIDEN NAME Marie Siegel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.0 DUE TO Generalized Peritonitis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Disrupted Ruptured Aorta (c) Disrupted Ruptured Aorta		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 20, 1961 to Dec 2, 1961 ; that (I) (we) last saw the deceased alive on Dec 2, 1961 , and that death occurred at 12/3/61 , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Blaine Schindker		22b. DATE SIGNED 12/3/61	
22c. PHYSICIAN'S NAME (Type) DR. BLAINE SCHINDER M.D.		22d. ADDRESS 43 GREENE STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-4-61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Plesent Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR DEC 5 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE James S. Piana	



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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13330

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg	
c. LENGTH OF STAY in 1b 14 hours		d. STREET ADDRESS Rt. #2 Box 391	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICK Middle McKENZIE Last McKENZIE		4. DATE OF DEATH Month 12 Day 14th Year 19 61.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1880
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81	IF UNDER 24 HRS. Hours 81 Min. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (County & State, or foreign country) Garrett County
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob McKenzie	
14. MOTHER'S MAIDEN NAME Fanny Christner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Frostburg, Md. Mrs. Wilma Femi, RT.#2, Box 391,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronch Pneumonia 450.0 DUE TO (b) Arterio Sclerosis DUE TO (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 Days yedis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Dec 13, 1961 to Dec 14, 1961 that (I) (we) last saw the deceased alive on Dec 14, 1961 and that death occurred at 9:50 A.M. from the causes and on the date stated above.	
22a. SIGNATURE W O Mc Lane M.D.		22b. DATE SIGNED Dec 15 1961	
22c. PHYSICIAN'S NAME (Type) W O Mc Lane MD		22d. ADDRESS Frostburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-16-61	23c. NAME OF CEMETERY OR CREMATORY St. Anne Cemetery	23d. LOCATION (City, town or county) (State) Avilton Md.
24. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		25a. REC'D BY REGISTRAR DEC 19 '61	
25b. REGISTRAR'S SIGNATURE Buriah H. Montecant		25c. REGISTRAR'S SIGNATURE DEC 19 '61	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY WELLERSBURG c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75-X-3 d. STREET ADDRESS 75-X-3	
3. NAME OF DECEASED (Type or print) First Middle Last PEARL E. MILLER		4. DATE OF DEATH Month Day Year DECEMBER 13 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 11, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days 76	IF UNDER 24 HRS. Hours Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) WELLERSBURG, PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FECHTIG, SAMUEL C.	
14. MOTHER'S MAIDEN NAME ANNA B. LONG		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive Heart Failure 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) ASHD		INTERVAL BETWEEN ONSET AND DEATH 3 day 10-14 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-10 , 19 61 , to 12-13 , 19 61 , that (I) (we) last saw the deceased alive on 12-13 , 19 61 , and that death occurred at 4:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 12/13/61	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 N. CENTRE STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 16, 1961	23c. NAME OF CEMETERY OR CREMATORY Cooks Cemetery	23d. LOCATION (City, town or county) (State) Wellersburg, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Harvey R. Zeigler		25a. REC'D BY REGISTRAR DEC 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanks		25c. ADDRESS Hyndman, Pa.	

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PENNSYLVANIA

ALLEGANY

WILLIAMSBURG

3 DAYS

CHESLAND

MEMORIAL HOSPITAL

WILLER

PERKINS

DECEMBER 13

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JAN. 11, 1935

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ET. WILE

U.S.A.

WILLIAMSBURG, PA.

ANN E. LONG

TECHNICAL, S.M.E.L.

MEMORIAL HOSPITAL, CHESLAND, MARYLAND

None

HO

Grade complete black fracture

Wt. 100 lbs. 10/10/35

ASHD

12-10

12-10

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301 W. CENTRAL STREET, CHESLAND, MD.

DR. WILLIAM S. JAMES

WILLIAMSBURG, PA.

Dec. 10, 1935

Box 101

WILLIAM S. JAMES

Wm. S. James

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be relayed by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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13352
13333
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/6/1952	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Johanna Middle Marie Last Mooney		4. DATE OF DEATH Month December Day 6 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1873
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Dignan		14. MOTHER'S MAIDEN NAME Marie Malloy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Hypertension, Secular degenerative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis (c) Phycoia Secular Cerebral degeneration		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/6/52 19 to 12/6/61 19, that (I) (we) last saw the deceased alive on 12/6/61 19 @ 9:30 P.M. and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 12/7/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/61	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR DEC 11 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Charles L. George	

SERVING

YOCO

References

12/01/2005

215 DE

STANDARD 10-10-10

13/5/51

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13353

CERTIFICATE OF DEATH

Reg. Dist. No. 13334

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>7yrs 18days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>A.</u> Middle <u>Morgan</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 / 2 / 1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Allegany County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas S. Allen</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. K.W. Condon, 4095 Renville Street, Detroit 10, Michigan</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Ch. Cholesterol & Scurvy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerosis & Diabetes</u> (b) <u>Arteriosclerosis & Diabetes</u> (c) <u>Arteriosclerosis & Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis & Diabetes</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-61</u> , 19 <u> </u> , to <u>12-29-61</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12-29-61</u> , 19 <u> </u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sylvan Retreat</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>L. B. Mathews</u> M.D.				PHYSICIAN'S NAME (Type) <u>L. B. Mathews, M.D.</u> <u>49 Greene Street, Cumberland, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 1, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHHORN</u> ADDRESS <u>LONACONING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 3 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

19210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13354

CERTIFICATE OF DEATH

Reg. Dist. No. 13335

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>5 yrs. 9 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland,</u>		d. STREET ADDRESS <u>1 Brooks Hotel, 202 Baltimore Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Morris</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/02</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Franklin Eaton</u>		14. MOTHER'S MAIDEN NAME <u>Alma Byron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-7014</u>	
17. INFORMANT <u>SYLVAN RETREAT RECORDS, CUMBERLAND, MD.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, (acute failure)</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis, & cerebral</u> DUE TO <u> </u> (c) <u>deterioration</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 1, 1961</u> , to <u>December 4, 1961</u> , that I last saw the deceased alive on <u>December 2, 19 61</u> , and that death occurred at <u>9:30A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>49 Greene St, Cumberland, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>L. B. Mathews</u> M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>L. B. Mathews, M.D.</u> <u>49 Greene St, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 6, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PATRICKS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CUMBERLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u> ADDRESS <u>CUMBERLAND, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 6 '61</u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

1935

NAME OF DECEASED MARTIN		DATE OF DEATH 1935	
AGE 25		SEX Male	
RACE White		MARRIAGE Single	
PLACE OF BIRTH Maryland		DATE OF BIRTH 1910	
STREET ADDRESS 1234 Main St.		CITY Baltimore	
COUNTY Baltimore		STATE Maryland	
OCCUPATION Student		EDUCATION High School	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1935		PLACE OF DEATH Home	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
DATE OF SIGNATURE 1935		DATE OF SIGNATURE 1935	
PLACE OF SIGNATURE Home		PLACE OF SIGNATURE Home	
NAME OF DECEASED MARTIN		DATE OF DEATH 1935	
AGE 25		SEX Male	
RACE White		MARRIAGE Single	
PLACE OF BIRTH Maryland		DATE OF BIRTH 1910	
STREET ADDRESS 1234 Main St.		CITY Baltimore	
COUNTY Baltimore		STATE Maryland	
OCCUPATION Student		EDUCATION High School	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1935		PLACE OF DEATH Home	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
DATE OF SIGNATURE 1935		DATE OF SIGNATURE 1935	
PLACE OF SIGNATURE Home		PLACE OF SIGNATURE Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

<div>1</div> <div>M</div> <div>I</div>										<div>13335</div> <div>13336</div>									
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Allegany</div> <div>MARYLAND</div>										<div>2. USUAL RESIDENCE (Where deceased lived, if institution, resident prior to admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Allegany</div>									
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Lonaconing</div>					<div>c. LENGTH OF STAY IN 1b</div> <div>72yrs</div>					<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>X Lonaconing</div>					<div>d. STREET ADDRESS</div> <div>Washington Street</div>				
<div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Washington Street</div>										<div>d. STREET ADDRESS</div> <div>Washington Street</div>									
<div>3. NAME OF DECEASED (Type or print)</div> <div>AGNES</div>										<div>4. DATE OF DEATH</div> <div>Month</div> <div>12</div> <div>Day</div> <div>13</div> <div>Year</div> <div>1961</div>									
<div>5. SEX</div> <div>Female</div>		<div>6. COLOR OR RACE</div> <div>White</div>		<div>7. MARRIED</div> <div><input type="checkbox"/> NEVER MARRIED</div> <div><input checked="" type="checkbox"/> WIDOWED</div> <div><input type="checkbox"/> DIVORCED</div>		<div>8. DATE OF BIRTH</div> <div>11/28/1889</div>		<div>9. AGE (In years last birthday)</div> <div>72 yrs.</div>		<div>IF UNDER 1 YEAR</div> <div>Months</div> <div>Days</div>		<div>IF UNDER 24 HRS.</div> <div>Hours</div> <div>Min.</div>							
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>None</div>					<div>10b. KIND OF BUSINESS OR INDUSTRY</div>					<div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>Lonaconing, MD.</div>					<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U-S-A</div>				
<div>13. FATHER'S NAME</div> <div>Jasper Atkinson</div>					<div>14. MOTHER'S MAIDEN NAME</div> <div>Mary Shaffer</div>														
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div>					<div>16. SOCIAL SECURITY NO. (If yes give number or date of service)</div>					<div>17. INFORMANT</div> <div>John Atkinson</div>					<div>Address</div> <div>Lonaconing, MD.</div>				
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>420.1 Myocardial Ischemia</div> <div>DUE TO</div> <div>(b) Atherosclerotic Cardiovascular Disease</div> <div>DUE TO</div> <div>(c)</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div>										<div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>2 months</div> <div>years</div>									
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</div>										<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>									
<div>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>					<div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</div>														
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m.</div> <div>p.m.</div>		<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town)</div>		<div>(County)</div>		<div>(State)</div>									
<div>21. I certify that (I) (this hospital) attended the deceased from</div> <div>Aug. 24, 1966</div> <div>to</div> <div>Dec. 13, 1961</div> <div>that (I) (we) last saw the deceased alive on</div> <div>Dec. 11, 1961</div> <div>and that death occurred at</div> <div>M</div> <div>from the causes and on the date stated above.</div>																			
<div>22a. SIGNATURE</div> <div>L. R. Miles, Jr.</div>					<div>22b. DATE SIGNED</div> <div>12-14-61</div>														
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>L. R. MILES, JR., M.D.</div>					<div>22d. ADDRESS</div> <div>LONACONING MD.</div>														
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>		<div>23b. DATE THEREOF</div> <div>12/16/1961</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Queens Point Cemetery</div>		<div>23d. LOCATION (City, town or county)</div> <div>Keyser, West Virginia</div>		<div>(State)</div>											
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>GEORGE EICHHORN</div>					<div>ADDRESS</div> <div>LONACONING, MD.</div>					<div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>DEC 18 '61</div>					<div>25b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Kiana</div>				

13332

Algeria

Longoria

Washington

AGNES

Female

Long

Lesper, W. H.

1/13/1901

11/23/1907

Longoria, M.

Longoria, M.

Longoria, M.

Longoria, M.

(1907-08)

Longoria, M.

Longoria, M.

Longoria, M.

Longoria, M.

Longoria, M.

Longoria, M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13356

13337

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 17 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				d. STREET ADDRESS 76 MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL J. O'NEAL		4. DATE OF DEATH DECEMBER 7, 1961					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 27, 1879	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (County & State, or foreign country) BARTON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN O'NEAL				14. MOTHER'S MAIDEN NAME SARAH MC MANUS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-7099		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left ventricular failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis; DUE TO (c) Coronary arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH immediate ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis; uremia; acute cystitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/20 , 19 61 to 12/6 , 19 61 , that (I) (we) last saw the deceased alive on 12/6 , 19 61 , and that death occurred at 8:30 A.M. the causes and on the date stated above.							
22a. SIGNATURE <i>Samuel M. Jacobson</i> 22c. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.		22b. DATE SIGNED 12/7/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-61		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town or county) (State) Frostburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Paul H. Montecant</i> Paul H. Montecant				25a. REC'D BY REGISTRAR DEC 11 61		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



13352

ALLIANCE

CLUBBING

THE CHILL HOSPITAL
WINTER & SPRING

MICHAEL

WIFE - WHITE

CHILDREN - 2

JOHN CHASE

HOME - 1

17 DAYS

CONDOMINUM

10 MAIN STREET

CHILL

SEATTLE 27, 1979

BARTON, WYLAND

SARAH JO WILKINS

THE CHILL HOSPITAL - CUMBERLAND, MD.

DR. SAMUEL W. JACOBSON

30 PERSHINE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined with 24 hours after the death. The law requires that the death certificate be examined with 24 hours after the death. The law requires that the death certificate be examined with 24 hours after the death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13357

CERTIFICATE OF DEATH

13338

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1 APT. 17 B. JANE FRAZIER VILLAGE e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) First OWENS Middle OWENS Last OWENS			4. DATE OF DEATH Month DECEMBER Day 30 Year 19 61		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH DECEMBER 29, 1961		9. AGE (In years last birthday) 1 yrs. Months 1 Days 1 Hours 1 Min.		10. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME FRANCIS J. OWENS			15. MOTHER'S MAIDEN NAME ERNESTINE BARBER		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			17. SOCIAL SECURITY NO.		
18. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MARYLAND			Address		
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intracranial hemorrhage DUE TO 760.20 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) premature baby (7 months) (c) premature separation of the placenta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 month					
INTERVAL BETWEEN ONSET AND DEATH 6 hours					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1961 to Dec. 30, 1961 , that (I) (we) last saw the deceased alive on Dec. 29, 1961 , and that death occurred 6:45 AM , from the causes and on the date stated above.					
22a. SIGNATURE L. Lewis M.D. DR. LEWIS BRINGS					
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)					
22d. ADDRESS 57 GREENE ST. CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/30/61		Vale Summit Cemetery	
23d. LOCATION (City, town or county)		(State)			
Vale Summit, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn			ADDRESS Lonaconing, Md.		
25a. REC'D BY REGISTRAR JAN 4 '62			25b. REGISTRAR'S SIGNATURE Christina L. Harris		

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1932

OUTPATIENT CLINIC

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MEMORIAL HOSPITAL

WARWICK & MEMORIAL

CUMBERLAND

ALLGANY

WHITE

IN

CHIEF

DECEMBER 30

ERNESTINE BARBER

WARWICK J. OWENS

MEMORIAL HOSPITAL-CUMBERLAND, WARWICK

[Faint handwritten notes and signatures in the center of the page.]

DR. LEWIS BRIDGES

ST. GREEN ST. CUMBERLAND, N.Y.

12/30/31 Vale Summit Cemetery

Burial

Vale Summit, N.Y.

George Johnson - Interment

(RECEIVED)

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13359

13340

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If death in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 460 PENNSYLVANIA AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUDREY Middle V. Last PIRKEY		4. DATE OF DEATH Month DECEMBER Day 19 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1918
9. AGE (In years, last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILFORD PIRKEY		14. MOTHER'S MAIDEN NAME SARAH GURTLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-12-2103	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid 153.3 DUE TO (b) metastatic carcinoma of Liver. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Thrombosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 19, 1961 5:13 P.M. to Dec 19, 1961 , that (I) (we) last saw the deceased alive on Dec 19, 1961 and that death occurred at 5:13 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 12/20/61	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-1961	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 28 '61	
25b. REGISTRAR'S SIGNATURE Clayton S. Harris			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13350

13341

1. PLACE OF DEATH a. COUNTY Allegheny MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE West Virginia f. COUNTY Mineral ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 27 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley 85X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS 19 Lyon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John Isaac Powelson			4. DATE OF DEATH 12-18-61 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21-1902		9. AGE (In years last birthday) 59 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire-room jammer		10b. KIND OF BUSINESS OR INDUSTRY Kellyspringfield Co (Tire Co.)		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Alvin Powelson (D)		
14. MOTHER'S MAIDEN NAME Mary Frances Lewison (D)			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		
16. SOCIAL SECURITY NO. 214-05-7644			17. INFORMANT Mrs. Letha C. Powelson 19 Lyon St., Ridgeley, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) apoplectic stroke DUE TO 334X Conditions, if any, which gave rise to immediate cause (b) arteriosclerosis (c) 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-2 , 19 60 , to 12-18 , 19 61 , that (I) (we) last saw the deceased alive on 12-18 , 19 61 , and that death occurred at 12-18 , 19 61 , from the causes and on the date stated above.					
22a. SIGNATURE Dr. L. Brings			22b. DATE SIGNED 12/20/61		
22c. PHYSICIAN'S NAME (Type) Dr. L. Brings			22d. ADDRESS 57 Greene Street		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/61		23c. NAME OF CEMETERY OR CREMATORY Nethkin Hill Cemetery	
23d. LOCATION (City, town or county) Elk Garden, W. Va.		23e. (State) W. Va.		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			24b. ADDRESS Cumberland, Md.		
25a. REC'D BY REGISTRAR DEC 26 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

13320

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Lowison

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John

John

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) LILLIE M. PRICE		4. DATE OF DEATH DECEMBER 21 1961		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MX 7-13-1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSEPH NORRIS				14. MOTHER'S MAIDEN NAME EMMA TRAIL				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Dis. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Generalized Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 11-26-61 to 12-21-61 , that (I) (we) last saw the deceased alive on 12-20-61 , and that death occurred at 5:55 A.M. from the causes and on the date stated above.															
22a. SIGNATURE W. F. Williams				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 12-21-61							
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-26-61		23c. NAME OF CEMETERY OR CREMATORIUM Big Ridge Cemetery				23d. LOCATION (City, town or county) (State) Little Orleans Allegany Md							
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Brown				ADDRESS Richard Brown				25a. REC'D BY REGISTRAR DEC 27 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13342

13361

ADULT

ADULT

ADULT

WHITE CHILD

WHITE CHILD

WHITE CHILD

HOSPITAL

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WHITE

HOUSE

HOUSE

JOSEPH MORRIS

JOSEPH MORRIS

JOSEPH MORRIS - GENERAL, WYOMING

JOSEPH MORRIS - GENERAL, WYOMING

JOSEPH MORRIS - GENERAL, WYOMING

JOSEPH MORRIS - GENERAL, WYOMING

DR. J. J. WILSON

122 S. CENTRAL STREET, CLEVELAND, OH.

JOSEPH MORRIS - GENERAL, WYOMING

JOSEPH MORRIS - GENERAL, WYOMING

1 FOR STATE HEALTH DEPT. NECESSARY, delay in filing this certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 60 2 01 2 VS. A15ME 5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13362

Item 7, Film G-306 1/30/62, cag. MARYLAND STATE DEPARTMENT OF HEALTH **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13343

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 223 Harrison Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 223 Harrison Street	
c. LENGTH OF STAY IN 1b Memorial Hospital		d. STREET ADDRESS 223 Harrison Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Purdham		4. DATE OF DEATH Month Day Year December 17 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/26/1898
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O Watchman Retired	11. BIRTHPLACE (State or foreign country) Luray, Virginia
10b. KIND OF BUSINESS OR INDUSTRY Railroad		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Lee Purdham		14. MOTHER'S MAIDEN NAME Lula Breedan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W. 1		16. SOCIAL SECURITY NO. 234-22-6567	
17. INFORMANT Memorial Hospital Cumberland, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMORRHAGE, DIFFUSE 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) SKULL FRACTURE (c) 903.5 DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell on sidewalk on Park and Harrison St.	
20c. TIME OF INJURY Month, Day, Year 5:30 p.m. Dec. 15 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Cumberland, Alleg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or country) R.D. 9 Cumberland, Md.			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) Dr. Benedict Skitarelic		DATE SIGNED December 19, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/61	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or country) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland		24. REC'D BY REGISTRAR DEC 22 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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SEXUAL PRACTICES

SUBORDINATE PERSONNEL, DUTY

Fell on sidewalk on Park and Harrison St.

5:30 - Dec. 15, 61 Street - Cumberland, Md.

December 19, 1961

A.D. Cumberland, Md.

13363
13344
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence O. Rafferty		4. DATE OF DEATH Dec. 5, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1914
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celinese		10b. KIND OF BUSINESS OR INDUSTRY Textiles	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Rafferty		14. MOTHER'S MAIDEN NAME Anastasia Scally Rafferty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-10-8954	
17. INFORMANT Mrs. Mary Condry, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 434.4 DUE TO Cardiac disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 days (c) 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4 Dec 1961 to 5 Dec 1961 , that (I) (we) last saw the deceased alive on 5 Dec 1961 , and that death occurred at 7:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE John B. Davis M.D.		22b. DATE SIGNED 12/5/61	
22c. PHYSICIAN'S NAME (Type) John B. Davis, MD		22d. ADDRESS Frostburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler		25a. REC'D BY REGISTRAR DEC 11 '61	
ADDRESS Hyndman, Pa.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be examined within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13364 CERTIFICATE OF DEATH 13345											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. Va. b. COUNTY Mineral					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ridgeley, 85X-3					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hosp.						d. STREET ADDRESS 18 Potomac St.,					
3. NAME OF DECEASED (Type or print) Mary Lillian Ridgley						4. DATE OF DEATH Dec. 26, 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Matron						10b. KIND OF BUSINESS OR INDUSTRY Deaf Institution			11. BIRTHPLACE (County & State, or foreign country) Vanderbilt, Penna.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME George W. Calhoun						14. MOTHER'S MAIDEN NAME Ida Shankle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No,						16. SOCIAL SECURITY NO. 216-14-1887					
17. INFORMANT Mr. Joseph J. Calhoun						Address Ridgeley, W. Va. 42 Knobley St.,					
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 28 hrs											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. 7:16/58 p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.											
20f. City or town (County) (State) Cumberland, Md.											
21. I certify that (I) (this hospital) attended the deceased from 7/6/58 , 19... to 12/26/61 , 19... that (I) was last saw the deceased alive on 12/26/61 , 19... and that death occurred at 7:12AM from the causes and on the date stated above.											
22a. SIGNATURE Richard J. Williams M.D.											
22b. DATE 12/27/61											
22c. PHYSICIAN'S NAME (Type) Richard J. Williams M.D.											
22d. ADDRESS 122 So. Centre St., Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 12/28/61											
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery,											
23d. LOCATION (City, town or county) (State) Cumberland, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.											
25a. REC'D BY REGISTRAR DEC 29 '61											
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas											



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13346

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 23yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 519 Virginia Ave.			d. STREET ADDRESS 519 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clifford Middle Robinson Last Robinson			4. DATE OF DEATH Month 12 Day 15 Year 19 61		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1905		9. AGE (In years last birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Jockey		10b. KIND OF BUSINESS OR INDUSTRY Race Track		11. BIRTHPLACE (State or foreign country) Rochester, N.Y.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Anna Melvin Address 519 Virginia Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC? M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 15, 1961 RR 9 Cumberland, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-61		22c. NAME OF CEMETERY OR CREMATORY Lorriane Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR DATE DEC 19 '61	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason therefor in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13366

13347

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE PIKE	
d. STREET ADDRESS ROUTE# 2 CUMBERLAND, MD		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ISSAC	First E.	Middle ROBISON	Last
4. DATE OF DEATH 10	Month 2	Day 19	Year 61
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-84
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY BREWERY	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME LUTHER ROBISON (D)		14. MOTHER'S MAIDEN NAME NANCY ROBISON (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 214 05 5026	
17. INFORMANT PATIENT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema and Congestive heart failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA, acute, prob. left cerebral hemisphere, with right hemiplegia and coma DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 24 hours 72 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralytic ileus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-29 , 19 61 , to 12-2 , 19 61 , that (I) (we) last saw the deceased alive on 12-1 , 19 61 , and that death occurred at 9:20am from the causes and on the date stated above.			
22a. SIGNATURE <i>Wyand F. Doerner</i> 22c. PHYSICIAN'S NAME (Type) Dr. WYAND F. JR. M. D.		22b. DATE SIGNED 12-3-61	
22d. ADDRESS 414 NORTH MECHANIC STREET		22e. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 5, 1961	
23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR DEC 6 '61	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE <i>William L. Harris</i>	

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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TO HOSPITAL 4th, Page 4
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after the death. The law requires that the death certificate be executed within 48 hours after the death. The law requires that the death certificate be executed within 48 hours after the death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13367											
13348											
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b Stoney Run d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport d. STREET ADDRESS Stoney Run e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) SYLVIA M. SCHUTZ					4. DATE OF DEATH Month Dec Day 9th Year 1961						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/1895		9. AGE (In years last birthday) 66 (rs.) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Charles Robertson					14. MOTHER'S MAIDEN NAME Margaret Thompson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. Mr. Charles Schutz, Frostburg, MD.					17. INFORMANT (SON)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Indefinite PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Ventricular failure, mild					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 11-19-61		(County) 12-9-61		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12-3-61 to 12-9-61 , that (I) (we) last saw the deceased alive on 12-3-61 , and that death occurred at 1:20p , from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Bess, Jr., M.D.					22b. DATE SIGNED 12-11-61						
22c. PHYSICIAN'S NAME (Type) Robert W. Bess, Jr., M.D.					22d. ADDRESS Box 247, Piedmont, W. Va.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/1961		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town or county) Frostburg, MD.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN					ADDRESS LONA CONING, MD.		25a. REC'D BY REGISTRAR DEC 13 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines		

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Library

Reference

History

1914

People

King

Charles Johnson

Charles Johnson

Mr. Charles Johnson, President

(1914)

Historical Information

Historical Information

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13368

13349

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If none, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. #2, WILLIAMS ROAD, CUMBERLAND, Md.	
f. STREET ADDRESS 1		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELLSWORTH H. SHOEMAKER		4. DATE OF DEATH Month Day Year DECEMBER 5, 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1887
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckdriver		10b. KIND OF BUSINESS OR INDUSTRY Moving, Transfer	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE SHOEMAKER		14. MOTHER'S MAIDEN NAME ANNA J. BAER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 214-05-6782	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Atherosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12/2/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State) Cumberland, Md.	
21. I certify that (I) (this hospital) attended the deceased from 12/2/60 to 12/5/60 , 19 61 , the (I) (we) last saw the deceased alive on 12/5/60 , 19 61 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. R. J. WILLIAMS		22b. DATE SIGNED DEC 11 '61	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR DEC 11 '61	
ADDRESS Cumberland, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1938

CERTIFICATE OF DEATH

1938

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111 32, WILLIAMS ROAD, CLEVELAND, OH.

111 32, WILLIAMS ROAD, CLEVELAND, OH.

111 32, WILLIAMS ROAD, CLEVELAND, OH.

GENERAL HOSPITAL - CLEVELAND, OH.

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Handwritten signature and text, likely a doctor's note or certificate.

Handwritten signature and text, likely a doctor's note or certificate.

Handwritten signature and text, likely a doctor's note or certificate.

111 32, WILLIAMS ROAD, CLEVELAND, OH.

111 32, WILLIAMS ROAD, CLEVELAND, OH.

111 32, WILLIAMS ROAD, CLEVELAND, OH.

TO HOSPITAL 1
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13369

13350

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If in a home, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS 622 FAIRVIEW AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last GROVER Cleveland SLAVEN		4. DATE OF DEATH Month Day Year DECEMBER 10, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Contract Painter Painting		10b. KIND OF BUSINESS OR INDUSTRY PAINTING	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ERNEST M. SLAVEN		14. MOTHER'S MAIDEN NAME Lula M. JOHNSTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-05-8717	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac Failure 422.1 DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Gen. arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Prostatitis INTERVAL BETWEEN ONSET AND DEATH 1 week 3 years ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12:57 to 10 Dec., 1961 , that (I) (we) last saw the deceased alive on 10 Dec., 1961 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer M.D.		22b. DATE SIGNED 12/12/61	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/61	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		25a. REC'D BY REGISTRAR DEC 15 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



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ALLIANCE

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USE PATRICK AVENUE

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DECEMBER 11

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9-20-100

VIRGINIA

EREST M. SLAYEN

EMMY A. JOHNSON

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. W. A. VAN ORMER

152 S. CENTRE ST., CUMBERLAND, MD.

Charles E. George, Cumberland, Md.

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13370

13351

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON, MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LESLIE Middle S Last SMITH			4. DATE OF DEATH Month 12/ Day 15 Year 19 61		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/97		9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN SMITH			14. MOTHER'S MAIDEN NAME MYRTLE SMITH		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)			16. SOCIAL SECURITY NO. 214-05411		
17. INFORMANT CHART			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory, cerebral, & circulatory DUE TO (b) anuric tubulosis, hypertension DUE TO (c) C.V. disease - arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 12/15 , 19 60 to 14/15 , 19 61 ; that (I) (we) last saw the deceased alive on 12/15 , 19 61 , and that death occurred at 2:03 PM, from the causes and on the date stated above.					
22a. SIGNATURE B. M. Schindler			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. B. M. SCHINDLER			22d. ADDRESS 43 GREENE STREET		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/18/61	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland Md.
24. FUNERAL DIRECTOR'S SIGNATURE E. S. Bual - Westernport, Md.			25a. REC'D BY REGISTRAR DEC 21 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Hines

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13371 CERTIFICATE OF DEATH 13352

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 HRS. 10 MIN.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS RT.#3, CHRISTY ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MEMORIAL HOSPITAL		First		Middle		Last SOWERS		4. DATE OF DEATH DEC. 25 1961		Month DEC.		Day 25		Year 1961	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 25, 1961		9. AGE (In years last birthday) 4		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Days 10		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME WILLIAM SOWERS		14. MOTHER'S MAIDEN NAME DOROTHY E. SIMPSON													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 781.5 IMMEDIATE CAUSE (a) Prematurity DUE TO (b) Premature separation of placenta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) See 21		(County) See 21		(State) MD.					
21. I certify that (I) (this hospital) attended the deceased from 12:42 PM to See 21 , 19 61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred 12:42 PM the causes and on the date stated above.		22a. SIGNATURE Oliver Nadeau		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) OLIVER NADEAU		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 12-25-61		23c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		23d. LOCATION (City, town or county) Cumberland, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, MD		ADDRESS		25a. REC'D BY REGISTRAR JAN 2 '62		25b. REGISTRAR'S SIGNATURE Charles S. Thomas									

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WILLIAM CONRAD

DOROTHY L. STIMPSON

MEMORIAL HOSPITAL

CONRAD, 10.

12:45 A.M.

OLIVER CONRAD

125 S. CENTRE ST., CONRAD, 10.

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13373 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13354											
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND c. LENGTH OF STAY IN 1b 15 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROUTE 3, BEDFORD ROAD						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND d. STREET ADDRESS ROUTE 3, BEDFORD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOUIS HERBERT STAIR						4. DATE OF DEATH DEC. 11, 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 7, 1889		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT				10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHRISTOPHER STAIR						14. MOTHER'S MAIDEN NAME MAGGIE CONN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I				16. SOCIAL SECURITY NO. 172 03 0309		17. INFORMANT PAUL A. STAIR		Address LA VALE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO CORONARY SCLEROSIS DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DECEMBER 11, 1961 Address (Street, city, town, or county) R 9 Cumberland, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF DEC. 13, 1961		22c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.			
23. FUNERAL DIRECTOR BYRON KIGHT ADDRESS CUMBERLAND, MD.						24a. REC'D BY REGISTRAR DEC 15 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13375 CERTIFICATE OF DEATH 13356											
Item 7 Film G302 12/15/61 ink											
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Eckhart d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ANTHONY V. STUCIN						4. DATE OF DEATH 12 4 19 61.					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-1918		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Worker				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.				11. BIRTHPLACE (County & State, or foreign country) Eckhart			
13. FATHER'S NAME Anthony Stucin, Sr.						14. MOTHER'S MAIDEN NAME Mary Ystonic					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 217-10-4818					
17. INFORMANT Mrs. Frank Sivic						Address R.D.#3, Box 114					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590X Acute Nephritis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Acute Rheumatoid Arthritis DUE TO (b) 4 days DUE TO (c) 13 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Dec 4 7:10 AM to Dec 4 6:20 PM , 19 61 , that (I) (we) last saw the deceased alive on Dec 4 1961 , and that death occurred 6:20 PM from the causes and on the date stated above.											
22a. SIGNATURE WOMcLane M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 7 1961			
22c. PHYSICIAN'S NAME (Type) WOMcLane MD						22d. ADDRESS Frostburg Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-61		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town or county) (State) Frostburg Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Basil H. Montecant						25a. REC'D BY REGISTRAR Hafer Funeral Home		25b. REGISTRAR'S SIGNATURE Arthur E. Hanes			
25c. ADDRESS 23 E. Main, Frostburg, Md.						DATE DEC 11 '61					

(M)

(1)

13373

13373

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13376

13357

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 36 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 522 LOUISIANA AVE.		
3. NAME OF DECEASED (Type or print) First ALMA Middle L. Last THOMAS			4. DATE OF DEATH Month DEC. Day 27 Year 19 61		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) GERMANY	
13. FATHER'S NAME JULIUS ANBREAS			14. MOTHER'S MAIDEN NAME ERNESTINA SHREIBER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HERMAN KARL THOMAS Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERY THROMBOSIS 422.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE (c) ARTERIOSCLEROSIS CARDIOVASCULAR DISEASE DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) COMMINUTED FRACTURE RIGHT HUMERUS					INTERVAL BETWEEN ONSET AND DEATH RECENT
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL OUT OF BED AT HOME			
20c. TIME OF INJURY Month, Day, Year 2 Hour DEC. 24 19 61 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) CUMBERLAND ALLEGANY	(County) MARYLAND	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 12/28/61
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					Address (Street, city, town, or county) 9 CUMBERLAND, MD.
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 30, 1961	22c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	22d. LOCATION (City, town, or country) (State) CUMBERLAND, MD.		
23. FUNERAL DIRECTOR ADDRESS BYRON KIGHT CUMBERLAND, MD.			24a. REC'D BY REGISTRAR JAN 2 '62 DATE	24b. REGISTRAR'S SIGNATURE <i>Charles L. Kraus</i>	

1985

WEEK 1 (20-26)

1985

(M)

(L)

52

1

1 5. 5

1/5/85

RECEIVED
MAY 1985

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

41
M

60

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13377						13358					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY ALLEGANY						a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
c. LENGTH OF STAY IN 1b 13 DAYS						d. STREET ADDRESS 104 S. GEORGE ST.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDITH VALENTINE						4. DATE OF DEATH DECEMBER 7, 19 61					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-1913		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE M. WOODS						14. MOTHER'S MAIDEN NAME EFFIE M. SMYTHE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO. 217 10 7809					
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive arterio-sclerosis (c) Penetrating duodenal ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 12-7-61 to 12-7-61 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland, Md.		(State) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-7-61 to 12-7-61 , that (I) (we) last saw the deceased alive on 12-7-61 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE W. F. Williams M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 12/6/61		
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS						22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town or county) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight						25a. REC'D BY REGISTRAR DEC 13 '61					
ADDRESS Cumberland, Md.						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

VR A15 (4)
15M 9/60

(M)

1937

ALLERGY

18 DAYS

CHURCHMAN

CHARLES J. KATZMAN, M.D.
METROPOLITAN HOSPITAL

100 S. GEORGE ST.

EDITH

VALERIE

WHITE

6-17-1913

18

GEORGE A. WOODS

EDITH M. WOODS

100 S. GEORGE ST. - GREENWICH, N.Y.

Prescription for
100 S. George St. - Greenwich, N.Y.
10-17-1913

10-17-1913

10-17-1913

DR. M. F. WELLS

100 S. GEORGE ST., GREENWICH, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **18359**

13378

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 yrs. 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roosevelt Middle William Last Wertz		4. DATE OF DEATH Month December Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/78
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shipyard Worker, Celanese Corp.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Wertz		14. MOTHER'S MAIDEN NAME Margaret Scank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Anna Wertz Address Cumberland Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Deceased Person's Cause 422.2 DUE TO (1) Myocardial Infarction, Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (2) Severe Psychosis DUE TO (3) Severe Psychosis (b) Severe Psychosis (c) Severe Psychosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1961 , to December 29, 1961 , that I last saw the deceased alive on Dec. 28, 1961 , and that death occurred at 1:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED Dec. 28, 1961			
ACTUAL SIGNATURE L. B. Mathews M.D.			
PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1962	
22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cath. Cemetery		22d. LOCATION (City, town, or county) (State) Bedford Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JAN 5 '62 24b. REGISTRAR'S SIGNATURE John S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

WILLIAM BONDE

WHITE MALE

AGE 63

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

Other Cause

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13379

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13360

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 523 VALLEY STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLIFFORD EUGENE WHITMAN				4. DATE OF DEATH DEC. 10 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 3, 1921	
9. AGE (In years last birthday) 40 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARMAN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK W. WHITMAN				14. MOTHER'S MAIDEN NAME GERTRUDE MYERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 213 12 9341		17. INFORMANT MRS. RHODA WHITMAN Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) HYDROTHORAX, ASCITES;; MARKED (c) PORTAL CIRRHOSIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				DATE SIGNED DECEMBER 10, 1961			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DECEMBER 10, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF DEC. 13, 1961		22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY	
23. FUNERAL DIRECTOR BYRON KIGHT				22d. LOCATION (City, town, or country) CUMBERLAND, MD.		24a. REC'D BY REGISTRAR DEC 13 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. House							

M

SECRET

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 must be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13380 CERTIFICATE OF DEATH 13361											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				d. STREET ADDRESS 124 POLK ST.	
d. NAME OF HOSPITAL (If institution, give full name and street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First FREDERICK Middle CALVIN Last WILSON						4. DATE OF DEATH Month DECEMBER Day 18 Year 19 61					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-9-1961		9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME ROY WILSON JR.						14. MOTHER'S MAIDEN NAME EDITH D. WILSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 776X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO DUE TO						INTERVAL BETWEEN ONSET AND DEATH 9 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.		Month, Day, Year 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CUMBERLAND		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 61 to 19 61 , that (I) (we) last saw the deceased alive on 19 61 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.											
22a. SIGNATURE W. P. A. Hodges						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. W. ROYCE HODGES						22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, or other method of disposal (Specify) Burial		23b. DATE THEREOF 12/19/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City, town or county) (State) Cumberland in Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.						ADDRESS Cumb. in Md.		25a. REC'D BY REGISTRAR DATE DEC 22 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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VS. A15ME
5M 7/59

MARYLAND
13362

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
19. INTERVAL BETWEEN ONSET AND DEATH		20. SUDDEN	
21. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. PART II. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25. 20c. TIME OF INJURY		26. 20d. INJURY OCCURRED	
27. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. 20f. (City or town)	
29. (County)		30. (State)	
31. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		32. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
33. ACTUAL SIGNATURE		34. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
35. EXAMINER'S NAME (Type)		36. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
37. DATE SIGNED		38. DECEASED'S NAME	
39. 22a. BURIAL, CREMATION, REMOVAL (Specify)		40. 22b. DATE THEREOF	
41. 22c. NAME OF CEMETERY OR CREMATORY		42. 22d. LOCATION (City, town, or country)	
43. 22e. (State)		44. 23. FUNERAL DIRECTOR	
45. 24a. REC'D BY REGISTRAR		46. 24b. REGISTRAR'S SIGNATURE	
47. DATE		48. ADDRESS	

FOR STATE
TO BE FILLED IN



Signature

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13382											
13363											
1. PLACE OF DEATH e. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland,					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 713 Fayette St.,						d. STREET ADDRESS 713 Fayette St.,					
3. NAME OF DECEASED (Type or print) First Jacob Middle Raymond Last Wolfe						4. DATE OF DEATH Month Dec. Day 26 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1880		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Wolf						14. MOTHER'S MAIDEN NAME Laura Pickering					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, Spanish Amer.						16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. William H. Buchholtz Address Cumb. Md.					
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 DUE TO Chronic Emphysema Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Branchio Pneumonia (c) 3 days						INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1961 to Dec. 26, 1961 , that (I) (we) last saw the deceased alive on Dec. 26, 1961 , and that death occurred at 10:25 M, from the causes and on the date stated above.											
22a. SIGNATURE W. Royce Hodges						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/27/61			
22c. PHYSICIAN'S NAME (Type) W. Royce Hodges M.D.						22d. ADDRESS 122 So. Centre St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/29/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery,			23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George						ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

632

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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13383
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13364

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY
Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
Maryland b. COUNTY
Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
3/21/1961 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Hattie Virginia Wolford | | 4. DATE OF DEATH
Month Day Year
December 14, 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/16/1881 |
| 9. AGE (In years lost birthday) yrs.
80 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Flintstone, Maryland | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Dr. Thomas Robosson | | 14. MOTHER'S MAIDEN NAME
Mary Boall | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
P.O.Box 599
Allegany County Infirmary records. | | Address
Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis, Degenerative, Scurvy
260X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.
(b) Arterio-sclerosis & Hypertension
DUE TO
(c) Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/21/61 19 to 12/14/61 19, that (I) (we) last saw the deceased alive on 12/14/61 19 @ 2:30 P.M. , and that death occurred at M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Lee B. Mathews | | 22b. DATE SIGNED
12/15/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Lee B. Mathews | | 22d. ADDRESS
49 Greene St., Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cemetery | | 23d. LOCATION (City, town, or county) (State)
Cumberland Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer Cumberland, Maryland | | 25a. REC'D BY REGISTRAR
DEC 22 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Conrad S. Thomas | | | |

1001-1500

17

PAGE NO.

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

13384
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
13365

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Allegany
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cumberland,
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
948 Gay St., | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
12 Cumberland,
d. STREET ADDRESS
950 Gay St.,
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
John Francis Woods | | 4. DATE OF DEATH
Month
Dec.
Day
6,
Year
19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 2, 1885 |
| 9. AGE (in years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months
Days | IF UNDER 24 HRS.
Hours
Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Laborer | |
| 11. BIRTHPLACE (State or foreign country)
Lonaconing, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Patrick Woods | | 14. MOTHER'S MAIDEN NAME
Mary Ann Keating | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No, | | 16. SOCIAL SECURITY NO.
164-10-3061 | |
| 17. INFORMANT
Allegany Co. Welfare Board, Cumb. Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intra-cranial hemorrhage
DUE TO
900.0
Fracture of skull
Conditions, if any, which gave rise to immediate cause (b)
(c) DUE TO
(a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fell down steps | | | |
| INTERVAL BETWEEN ONSET AND DEATH
10 Min.
10 Min. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Fell down steps | |
| 20c. TIME OF INJURY
Month, Day, Year
6:00 p.m. Dec. 6, 19 61 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Neighbors home | 20f. (City or town) (County) (State)
Cumberland, Allegany Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
12/7/61 | |
| EXAMINER'S NAME (Type)
Benedict Skitarelic M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rt. # 9 Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12/9/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Allegany Co. Cemetery | | 22d. LOCATION (City, town, or country) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR
Charles L. George Cumberland, Md. | | 24a. REC'D BY REGISTRAR
DEC 11 '61 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Krause | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13366

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Allegheny
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Flintstone
c. LENGTH OF STAY IN b
Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Flintstone, Maryland | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Allegheny
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Flintstone
d. STREET ADDRESS
1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Mary D. Mertie Yeager | | | | 4. DATE OF DEATH
Month Dec. Day 23 Year 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 18, 1873 | |
| 9. AGE (In years last birthday)
88 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Amos C. Gross | | | | 14. MOTHER'S MAIDEN NAME
Amanda Hendrickson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. James W. Davis Flintstone, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) MYOCARDIAL FAILURE
(a), stating the underlying cause last. (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL HEMORRHAGE APRIL 1961
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) R.9 Cumberland, Md. | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. | | DATE SIGNED December 23, 1961 | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | Address (Street, city, town, or county) R.9 Cumberland, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
12-26/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Pleasant Grove Cem. | | 22d. LOCATION (City, town, or country) (State)
Balto. Pike Cumberland, Md. | |
| 23. FUNERAL DIRECTOR
John J. Hofer | | ADDRESS
Cumberland, Md. | | 24a. REC'D BY REGISTRAR
DEC 28 '61 | | 24b. REGISTRAR'S SIGNATURE
William S. Hanes | |

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